

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30901

State File No. ....

4406

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u> )		c. LENGTH OF STAY (in this place) <u>25 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>510 East 8th St. Apt. # 3136</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alphonse</u>		b. (Middle) <u>Joseph</u>		c. (Last) <u>Walters</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 15, 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced 3</u>		8. DATE OF BIRTH <u>Jan. 1, 1904</u>		9. AGE (In years last birthday) <u>50 years</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ray's Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Cedar Rapids, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>No record</u>		13b. MOTHER'S MAIDEN NAME <u>No record</u>		14. NAME OF HUSBAND OR WIFE <u>No record</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-10-3720</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Josephine Bright 510 East 8th.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of liver</u>				I month			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4-26</u> , 19 <u>54</u> , to <u>9-15</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>54</u> , and that death occurred at <u>7:25 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W.W. Dodson M.D.</u>				23b. ADDRESS <u>1010 Professional Building</u>		23c. DATE SIGNED <u>9-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 18, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-16-54</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas E. Quirk 4316 Troost Ave.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300  
48

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

3775

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.