

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40531

State File No. ....

FILED DEC 16 1954

BIRTH NO. _____		REG. DIST. NO. <u>107</u>		PRIMARY REG. DIST. NO. <u>3019</u>		Registrar's No. <u>159</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kennett</u>		c. LENGTH OF STAY (in this place) <u>5 yrs</u>		c. CITY OR TOWN <u>Kennett</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>901 Anthony St.</u>				f. STREET ADDRESS (If rural, give location) <u>901 Anthony St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>THOMAS</u> c. (Last) <u>WALTERS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12-11-1954</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>7/1/1872</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Paik Co Ill</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Dry Goods</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>George Walters</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs Amanda Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Myrtle Watson, Malden MO, Ill.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Dist.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Indurational Myocarditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		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>Dec 11</u> , 19 <u>54</u> , to <u>Dec 11</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11-54</u> , 19 <u>54</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (If three or title) <u>A T Simpson</u>				23b. ADDRESS <u>Kennett MO</u>		23c. DATE SIGNED <u>12-13-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/13/1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>		24d. LOCATION (City, town, or county) (State) <u>Kennett MO</u>	
DATE REC'D BY LOCAL REG. <u>12-13-54</u>		REGISTRAR'S SIGNATURE <u>Carl Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emerson P. Son</u>		ADDRESS <u>Jamestown Ark</u>	

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

RECEIVED DUNKLIN COUNTY HEALTH  
DEPARTMENT 12-15-54  
COUNTY FILE NUMBER 1254-3

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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 .....  
Signature of Student Embalmer

Signed *Tom Jensen* .....

Licensed Embalmer No. *89*

P. O. Address *Jonestown* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.