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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 29 1955

State File No. 37073  
4874

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>50 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2109 Olive Street</b>		e. STREET ADDRESS (If rural, give location) <b>2109 Olive Street 33275</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Gertrude</b>	b. (Middle) <b>B.</b>	c. (Last) <b>Walker</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 7, 1955</b>
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5. SEX <b>3</b> <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 2, 1888</b>	9. AGE (In years) (last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Dennison, Texas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Ernest Walker</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY <b>500-12-7766</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Nadine B. Davis, Omaha, Nebr.</b>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>4221</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pulmonary Edema + Congestion</b> DUE TO (c) <b>Chronic Adhesive Pleuritis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Arteriosclerosis</b> <b>Chronic Interstitial Nephritis</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>L. M. Hillman</b> (Degree or title) <b>Deputy Coroner</b>	23b. ADDRESS <b>M. D. 1618 Lydia Ave.</b>	23c. DATE SIGNED <b>11/9/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11/14/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery Kansas</b>	24d. LOCATION (City, town, or county) (State) <b>St. Leavenworth, Kansas</b>
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DATE REC'D BY LOCAL REG. <b>11-11-55</b>	REGISTRAR'S SIGNATURE <b>Deva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Badeau, Appleton &amp; Jones, Inc., K.C., Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
L. M. Hillman

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 *Conrado G. Galup / Bal*

Licensed Embalmer No. *494*

P. O. Address *K.S. hu*

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.