

FILED APR 9 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10078

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>2052</u>		Registrar's No. <u>173</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (In this place) <u>39 yrs</u>		c. CITY OR TOWN <u>Sedalia</u>		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 <u>414 West 16th</u>				STREET ADDRESS (If rural, give location) <u>414 West 16th</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nellie</u>			b. (Middle) <u>LEORA</u>		c. (Last) <u>Walker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 2 1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 6 1900</u>		9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Altona Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Russel G. Demmon</u>			13b. MOTHER'S MAIDEN NAME <u>Lavina Whinery</u>		14. NAME OF HUSBAND OR WIFE <u>August Walker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>August Walker</u>		ADDRESS <u>Sedalia</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension & Valvular</u> DUE TO (c) <u>Heart Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u> 6 Years			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				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) _____		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 _____, 19 <u>50</u> , to <u>4-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>56</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. T. Jones M.D.</u>				23b. ADDRESS <u>Sedalia, Missouri</u>		23c. DATE SIGNED <u>4-3-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-4-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>		
DATE REC'D BY LOCAL REG. <u>4-4-56</u>		REGISTRAR'S SIGNATURE <u>Lavina Coontz, Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Laughlin Bros</u>		ADDRESS <u>Sedalia</u>	

Licensed Embalmer's Statement on Reverse Side

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

300
48

MS JUN 23 1960

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.....
Licensed Embalmer No.

P. O. Address.....
Sedalia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.