

FILED SEP 26 1956

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29995

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>44</u>		PRIMARY REG. DIST. NO. <u>4062</u>		Registrar's No. <u>40</u>	
1. PLACE OF DEATH a. COUNTY <u>Caldwell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Caldwell</u>			
b. CITY OR TOWN <u>Cowgill</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Cowgill</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>RFD#1</u>				e. STREET ADDRESS (If rural, give location) <u>RFD#1</u> <span style="float: right;">0130</span>			
3. NAME OF DECEASED a. (First) <u>William</u>			b. (Middle) <u>Oliver</u>		c. (Last) <u>De Walt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9 17 56</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov-27-1876</u>		9. AGE (In years last birthday) <u>79</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>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Newton Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob S De Walt</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Ashworth</u>		14. NAME OF HUSBAND OR WIFE <u>Memmie M De Walt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Memmie M De Walt</u> ADDRESS _____			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</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.  5					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>321x</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 <u>Jan 1</u> , 19 <u>80</u> , to <u>Sept 17</u> , 19 <u>56</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:20 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>O.C. Kilbourn, M.D.</u>			23b. ADDRESS <u>Cowgill, Mo.</u>		23c. DATE SIGNED <u>9-17-56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-19-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Graceland</u>		24d. LOCATION (City, town, or county) (State) <u>Camaral Mo</u>		
DATE REC'D BY LOCAL REG. <u>9-21-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Lathlean Jorgensen</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert Funeral Home Camaral</u>			

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

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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 *Robert J. Paland*.....

Licensed Embalmer No. *4777*.....

P. O. Address *Cameron*.....

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.