

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Potte 42087  
STATE FILE NUMBER

FILED JAN 2 1957

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 139

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional; Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctors Hospital</u> Length of stay in 1b <u>1 day</u>		d. STREET ADDRESS <u>21 1/2 N Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE PATRICK WALKER</u> First Middle Last			4. DATE OF DEATH <u>Dec-20-1956</u> Month Day Year
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June-15-1885</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Garage Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Shariton Mo</u>
13. FATHER'S NAME <u>Elmer Walker</u>		14. MOTHER'S MAIDEN NAME <u>Dr K</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>497-30-643</u>	17. INFORMANT <u>Beatrice Walker</u> Address <u>Brookfield Mo</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterial Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>332X</u>		
20c. TIME OF INJURY Hour Month, Day, Year <u></u> a. m. <u></u> p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Dec 15 1956</u> , to <u>Dec 20 1956</u> and last saw her alive on <u>Dec 19</u> Death occurred at <u>11257</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. H. Potte</u>		22b. ADDRESS <u>Brookfield Mo</u>	22c. DATE SIGNED <u>12-22-56</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	23b. DATE <u>12-24-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Michael Bern</u>	23d. LOCATION (City, town, or county) <u>Brookfield</u> (State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>J. H. Blacklock</u> ADDRESS <u>Brookfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-24-56</u>	26. REGISTRAR'S SIGNATURE <u>Katherine Johnson</u>

(Licensed Embalmer's Statement on Reverse Side)

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-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**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 *J. B. Blacklock*.....

Licensed Embalmer No. *23*

P. O. Address *Brookfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If not so signed, 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.