

Health,
L. Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32299

STATE FILE NUMBER

FILED SEP 19 1957

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 403

300
1-570

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Independence</i>		c. CITY OR TOWN <i>Independence, Mo.</i>	
c. FULL NAME OF (If NOT in hospital, give location) <i>Indy. Sanitarium</i>		d. STREET ADDRESS (If outside, give location) <i>210 1/2 W. Walnut</i>	

3. NAME OF DECEASED (Type or print) First <i>WALTER</i> Middle <i>-</i> Last <i>MEDLEY</i>			4. DATE OF DEATH Month <i>SEPT</i> Day <i>9</i> Year <i>1957</i>			
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 20 1891</i>	9. AGE (In years last birthday) <i>66</i>	10. F UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most working life, even retired) <i>Wreck Assembler</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Dover Mfg. Co.</i>	11. BIRTHPLACE (City and state or country) <i>Webster Co. Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Joel Medley</i>	13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Rebecca Medley</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>440-22-4928</i>	17. INFORMANT <i>Roscoe E. Medley</i>	Address <i>5101 Crest Drive H.C.K.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Gastrointestinal hemorrhage</i> DUE TO (b) <i>Ruptured Esophageal Varices</i> DUE TO (c) <i>Cirrhosis of the liver</i>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Primary Carcinoma of the liver</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <i>-</i> Month, Day, Year <i>-</i> a.m. <i>-</i> p.m. <i>-</i>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>5810H</i>	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from _____, to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>James S. Bridgers M.D.</i>	(Degree or title)	22b. ADDRESS <i>1509 W. Truman Rd.</i>	22c. DATE SIGNED <i>10 Sept 57</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Sept. 12-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Kansas City, Mo.</i>
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24. FUNERAL DIRECTOR <i>C. H. Blackman & Son Inc.</i>	ADDRESS <i>K.E. Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>9-12-57</i>	26. REGISTRAR'S SIGNATURE <i>James S. Bridgers</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc., may use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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SEP 18 1957

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 *W.C. Purvine*

Licensed Embalmer No. *4879*
P. O. Address *N.C. 7th*

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.