

Health,
Welfare
Public
Service

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-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard instruments. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-9-009625
STATE FILE NUMBER

Dr. Musick
FILED MAR 17 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 255

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 0396		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burhe Hosp.		Length of stay in lb 30 Yrs.	d. STREET ADDRESS 810 S. Jefferson		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle B. Last WALKER			4. DATE OF DEATH Month March Day 10 Year 1958			
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9 1876	9. AGE (In years birthday) 82	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hardware Co.	11. BIRTHPLACE (City and state or country) Ohio, Iowa /		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Walker		13b. MOTHER'S MAIDEN NAME Elizabeth		14. NAME OF HUSBAND OR WIFE Mayme Walker (Dec.)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address Mrs. G.R. Butts Rockville, My.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma Cervical Glands					INTERVAL BETWEEN ONSET AND DEATH Not known	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2002					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.)				
20c. TIME OF INJURY Hour a.m. p.m.						
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	
21. I attended the deceased from Jan. 21, 1958 to 3, 9, 58 and last saw him alive on 3, 9, 58 Death occurred at 3 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.			22b. ADDRESS 505 Med. Arts Bldg Springfield, Mo.		22c. DATE SIGNED 3, 11, 58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/15/58	23c. NAME OF CEMETERY OR CREMATORY Maple Park		23d. LOCATION (City, town, or county) (State) Springfield, Mo.		
24. FUNERAL DIRECTOR ADDRESS H.H. Lohmeyer Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 3-14-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Cmt

Signed *R. L. Mc Corm*

Licensed Embalmer No. *2727*
P. O. Address *Springfield*

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.