Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-020248
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5650

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis 0 Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lutheran Hosp. Length of stay in 1b 15 9 239

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1610 S. 11th st. Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First GOLDIE Middle MAY Last WALLER
4. DATE OF DEATH Month 5 Day 30 Year 58
5. SEX female 1
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-3-1903
9. AGE (In years last birthday) 54 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) housewife
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (City and state or country) Salem, Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Wm. R. Dunlap
13b. MOTHER'S MAIDEN NAME Nora unknown
14. NAME OF HUSBAND OR WIFE George Waller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address George Waller, 1610 S. 11th st.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Autolytic Perforation of Esophagus — INTERVAL BETWEEN ONSET AND DEATH Sev. hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Fistula of Common Duct → 6 mths
DUE TO (c) Pancreatitis Endometriosis → Sev. Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease conditions given in PART I (a)
Cachexia - Generalized Debilitation
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 587.0
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11/2/51, to 5/30/58 and last saw her alive on 5/29/58
Death occurred at 2:55 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Walter H. Hogge MD (Degree or title)
22b. ADDRESS 3108 S. Grand
22c. DATE SIGNED MAY 31 58

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 5-31-58
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Corning, Ark.

24. FUNERAL DIRECTOR ADDRESS Russell-Ermert, Corning, Ark.
25. DATE RECD. BY LOCAL REG. MAY 31 '58
26. REGISTRAR'S SIGNATURE J. Carl Smith MD N.G.R.

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed Pearl E. Marre

Signature of Student Embalmer

Licensed Embalmer No. 3360

P. O. Address 21 Kane

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.