

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035862  
STATE FILE NUMBER

OCT 30 1958 Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 312

1. PLACE OF DEATH a. COUNTY <b>Cole</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jefferson City,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb <b>1 hour</b>	d. STREET ADDRESS (If outside, give location) <b>126 R # 3</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>WALKER</b> Last <b>WALKER</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>26,</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1881</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Osage County Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>George Strickland</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy South</b>		14. NAME OF HUSBAND OR WIFE <b>David Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. August Raithel, Jefferson City, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT <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 <b>10/26/58</b> to <b>10/26/58</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>10/26/58</b> Death occurred at <b>9:15</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>J. Karagawa MD</b> (Degree or title)			22b. ADDRESS <b>515 E High St</b>		22c. DATE SIGNED <b>10/28/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/29/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran</b>		23d. LOCATION (City, town, or county) (State) <b>Schuberts, Mo</b>
24. FUNERAL DIRECTOR <b>Clyde Morton,</b> ADDRESS <b>Linn, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>28 October 1958</b>		26. REGISTRAR'S SIGNATURE <b>R. P. Norris, MD-MR.</b>	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

0

8  
0

8961 9 NOV 1958

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 *Thomas M. Motta* .....

Licensed Embalmer No. *4125* .....

P. O. Address *Linn Mo.* .....

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.