

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039235
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 69 Primary Registration District No. 4122 Registrar's No.

1. PLACE OF DEATH a. COUNTY Christian		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nixa		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Nixa 6220
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION residence		Length of stay in 1b. 92 years	d. STREET ADDRESS (If outside, give location) no street address
3. NAME OF DECEASED (Type or print) First Middle Last FLORA R. WALKER			4. DATE OF DEATH Month Day Year Nov. 8, 1958
5. SEX Female	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 Sept. 27, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 92
11a. FATHER'S NAME John Thomas Wasson		11b. MOTHER'S MAIDEN NAME Lucinda Caroline McCullah	11c. NAME OF HUSBAND OR WIFE Thomas B. Walker
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. none	17. INFORMANT Address Springfield, Mo. John M. Rice, 1500 Fairway Terrace.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebra arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senility DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 334X			INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. 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 10-29-58 to death and last saw ^{her} _{him} alive on 11-3-58 Death occurred at 9:30 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Samuel F. Wilson</i> (Degree or title) 2		22b. ADDRESS Nixa Mo	22c. DATE SIGNED 11-12-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/10/1958	23c. NAME OF CEMETERY OR CREMATORY Glenn Cemetery	23d. LOCATION (City, town, or county) (State) Nixa, Missouri
24. FUNERAL DIRECTOR <i>Jean Harris</i> ADDRESS Clever, Mo.		25. DATE RECD. BY LOCAL REG. Nov. 15, 1958	26. REGISTRAR'S SIGNATURE <i>Olive Hunter</i>

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Sean Harris*

Licensed Embalmer No. *4390*

P. O. Address *Clarks, 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.