THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004352
STATE FILE NUMBER

Filed MAR 16 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 79

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) North Hosp — Length of stay in Hospital 2 Weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Sullivan
c. CITY OR TOWN Kirksville — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Mell Middle Engelhart Last Walters
4. DATE OF DEATH Month 3 Day 4 Year 1959
5. SEX Fem
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 12-27-1880
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months 2 Days 29 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Kirksville - Mo
12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Charles Engelhart
13b. MOTHER'S MAIDEN NAME Jane Verdin
14. NAME OF HUSBAND OR WIFE Henry Walters (dead)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Hugh Clark - Joplin - Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Toxemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) intestinal gangrene + obstruction
DUE TO (c) Mesenteric thrombosis
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) 5703.
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.)
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 2-15-59, to 3-4-59 and last saw her alive on 3-4-59
Death occurred at 7:00 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Addison Homber (Degree or title) MD
22b. ADDRESS Kirksville Mo
22c. DATE SIGNED 3-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3-6-1959
23c. NAME OF CEMETERY OR CREMATORY Oakwood Cem
23d. LOCATION (City, town, or county) Milan (State) Mo

24. FUNERAL DIRECTOR Schoene & Home — ADDRESS Milan Mo
25. DATE RECD. BY LOCAL REG. 3-10-1959
26. REGISTRAR'S SIGNATURE Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be correctly related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Addison Homber MD

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Mulan - 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.