

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005310

STATE FILE NUMBER

REC FEB 24 1959

Registration District No.

137

Primary Registration District No.

3023

Registrar's No.

41

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Wetzel Jstee Hosp</u>			Length of stay in 1b <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>630 W Allen</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Melissa</u> Last <u>Walters</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1891</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Wm. H. Simmons</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Earl Walters</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>495-36-6182</u>		17. INFORMANT <u>Louise W. Williams</u> Address <u>Flower</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Pulmonary Bronchiectasis</u>						<u>20 days</u>	
DUE TO (c) <u>Bronchial Asthma</u>						<u>25 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atelectasis & Pulmonary Emphysema</u>						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 <u>12</u> Month <u>1</u> Day <u>15</u> Year <u>1958</u> o.m. <u>05</u> p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>12/1/58</u> , to <u>2/16/59</u> and last saw <u>her</u> alive on <u>2/16/59</u> Death occurred at <u>12:05 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Clinton R. Sleep, A.O.</u>				22b. ADDRESS <u>105 E. Ohio, Clinton, Mo.</u>		22c. DATE SIGNED <u>2/17/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>		
24. FUNERAL DIRECTOR <u>Consoler Clinton</u>				ADDRESS <u>Clinton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 26 1953

MAR 5 1959

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

....., Student Embalmer No.

working under my personal supervision.

Student
Signature of Student Embalmer

Signed *J E Combs*
almer

Licensed Embalmer No. *1891*
P. O. Address. *Clinton*

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.