

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-005946
 STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 466

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) General Hospital #2		Length of stay in lb 40yrs	d. STREET ADDRESS (If outside, give location) 1522 Lydia Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Florine Middle Walker Last Walker			4. DATE OF DEATH Month 1 Day 22 Year 59
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-18 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months 40 Days 0 Hours 0 Min. 0
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? United States	
13a. FATHER'S NAME Ralph Walker		13b. MOTHER'S MAIDEN NAME Della Walker	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOC. SEC. NO. 493-12-8897	17. INFORMANT Erma Turner Address 1523 Tracy
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Partial intestinal obstruction			INTERVAL BETWEEN ONSET AND DEATH
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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 11-4-58 to 1-22-59 and last saw her/him alive on 1-22-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 600 E. 22nd Street	22c. DATE SIGNED 1-23-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/25/59	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge	23d. LOCATION (City, town, or county) (State) K C Mo
24. FUNERAL DIRECTOR Manlove Williams 1729 Lydia		25. DATE RECD. BY LOCAL REG. 1-24-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

E. Frank Ellis

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, ~~only~~....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Maxwell Wilkins*.....
Licensed Embalmer No. *4653*.....

P. O. Address *1729 Lybia*.....

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.