

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009722  
STATE FILE NUMBER  
1412

FILED APR 2 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1412

300  
-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If inside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		c. CITY OR TOWN <i>Kansas City</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Gen. Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>1615 Jefferson</i>	
3. NAME OF DECEASED (Type or print) First <i>MARIE</i> Middle <i>Jr.</i> Last <i>WALSH</i>		4. DATE OF DEATH Month <i>3</i> Day <i>15</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-2-1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>68</i>
11. BIRTHPLACE (City and state or country) <i>Kansas City Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>W. M. Stout</i>		13b. MOTHER'S MAIDEN NAME <i>No Record</i>	
14. NAME OF HUSBAND OR WIFE <i>Leo M. Walsh</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>493-32-4908</i>		17. INFORMANT Address <i>Wallace A. Walsh, 1010 W. 16th Terr.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recent Cerebral encephalomalacia</i>			INTERVAL BETWEEN ONSET AND DEATH
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)			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <i>3-14-59</i> to <i>3-15-59</i> and last saw <sup>her</sup> <sub>him</sub> alive on <i>3-15-59</i> Death occurred at <i>5:30 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Abraham Gelperin</i> (Degree or title) _____		22b. ADDRESS <i>Gen. Hospital</i>	
22c. DATE SIGNED <i>3-15-59</i>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-18-59</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo</i>	
24. FUNERAL DIRECTOR <i>Wagner Funeral Home, K.C. Mo</i>		25. DATE RECD. BY LOCAL REG. <i>3-17-59</i>	
26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
 Abraham Gelperin M.D. 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 *Alvin R. Harnischfeld* .....

Licensed Embalmer No. *4159* .....  
P. O. Address *K. C. 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.