

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010494
STATE FILE NUMBER

FILED MAR 18 1959 Registration District No. 290 Primary Registration District No. Registrar's No. 23

300
1-57

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fort Leonard Wood ⁰⁸⁵⁰ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Length of stay in 1b --	d. STREET ADDRESS (If outside, give location) 194 Pulaski St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Wendy Middle Jo Last Walters			4. DATE OF DEATH Month March Day 10 Year 1959			
---	--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Sep 1958	9. AGE (In years last birthday) 5	IF UNDER 1 YEAR Months 22	IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	---------------------------------	--------------------------------------	------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	-------------------------------------

13a. FATHER'S NAME James L Walters	13b. MOTHER'S MAIDEN NAME Frances Lee Dunkel	14. NAME OF HUSBAND OR WIFE -----
---------------------------------------	---	--------------------------------------

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. -----	17. INFORMANT James L Walters	Address 194 Pulaski St Ft Leonard Wood, Mo
---	----------------------------------	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Electrolyte imbalance		
DUE TO (c) Infantile diarrhea		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5110		19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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
---	--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION COUNTY STATE
---	--

21. I certify that the deceased died on <u>10 Mar 1959</u> at <u>2:05</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>H. Baruch</i> H. BARUCH Capt MC	22b. ADDRESS US Army Hospital Ft Leonard Wood, Missouri	22c. DATE SIGNED 10 Mar 59
---	---	-------------------------------

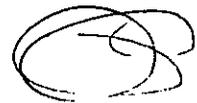
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/12/59	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) Pleasant Plains IL
--	----------------------	---	---

24. FUNERAL DIRECTOR <i>Hodges Funeral Home Inc</i>	DATE RECD. BY LOCAL REG. 3-12-59	REGISTRAR'S SIGNATURE <i>Paula Grace Anderson</i>
--	-------------------------------------	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be only standard nomenclature as item 10. No symptoms will be listed.



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 *James Snow*

Licensed Embalmer No. *4896*

P. O. Address *Waynesville, N.C.*

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.