RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-020504
STATE FILE NUMBER

FILED JUN 30 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 642

IDED

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Joseph — Length of stay in 1b: 11years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Arnold Nursing Home 701 S. 11th — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St.Joseph — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 538 So.38th — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle ANTHONY Last WALKER
4. DATE OF DEATH: Month June Day 14, Year 1959

5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 10/26/1888
9. AGE (last birthday): 70 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Re. Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (City and state or country): Gentry County,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
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.: unknown
17. INFORMANT Address: James W. Walker,Kamsas City,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): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic myocarditis
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 March 18,1959, to June 14,1959 and last saw him alive on June 14,1959
Death occurred at 7:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dr Raymond L Smith D.O.
22b. ADDRESS: 209 Kirkpatrick Bldg
22c. DATE SIGNED: 6/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6/15/1959
23c. NAME OF CEMETERY OR CREMATORY: Hamburg Cemetery
23d. LOCATION (City, town, or county) (State): Hamburg Iowa

24. FUNERAL DIRECTOR: John Rupp — ADDRESS: St.Joseph,Mo
25. DATE RECD. BY LOCAL REG.: June 22, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

CERTIFICATION

Raymond L Smith D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

~~or by~~ _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 398

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.