

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 64 59-025849

FILED VS AUG 12 1959

Registration District No. 285 Primary Registration District No. 3039 Registrar's No. 3039 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lenn</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Lenn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline MO</u>	Length of stay in 1b <u>7 1/2 months</u>	c. CITY OR TOWN <u>Brookfield</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>644 Crosby</u>

3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Walsh</u> Last <u>Beall</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1959</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/23/91</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR	
				Months <u>11</u> Days <u>13</u> Hours <u></u> Min. <u></u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>co owner of Lbr. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>Thomas Walsh</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Rooney</u>		14. NAME OF HUSBAND OR WIFE	
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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>494-40-8691</u>		17. INFORMANT <u>John E Walsh</u> Address <u>Brookfield MO</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>stroke</u>			<u>month</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>			<u>year</u>		
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.		
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

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.)			
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from 1957 to 1959 and last saw her live on 2-6-59
 Death occurred at B. D. Howell on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B D Howell</u> (Degree or title)		22b. ADDRESS <u>Brookfield, Mo</u>		22c. DATE SIGNED <u>8-8-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield MO.</u>
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24. FUNERAL DIRECTOR <u>Bowdoin Brookfield, MO</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Bronnie Owens</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1962

SEP 8 1962

APR 10 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. McCalla

Licensed Embalmer No. 4230

P. O. Address Brookfield

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.