

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 44 3 7 0

FILED VS DEC 21 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5869

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 9 YRS		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) HOSPITAL OR INSTITUTION OSTEOPATHIC HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2619 E. 10TH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DENVER Middle CLIFTON Last WALLS				4. DATE OF DEATH Month DEC Day 5 Year 1959					
5. SEX MALE	6. COLOR OR RACE CAU	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/31/24	9. AGE (last birthday) 34	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPOT WELDER			10b. KIND OF BUSINESS OR INDUSTRY BENDO COMPANY		11. BIRTHPLACE (City and state or country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME FONSO WALLS			13b. MOTHER'S MAIDEN NAME MEMORY STONE			14. NAME OF HUSBAND OR WIFE NORMA L. WALLS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) NO			16. SOCIAL SECURITY NO. 236-34-4389		17. INFORMANT Address MRS. NORMA L. WALLS 2619 E. 10TH K.C. 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) Respiratory Center Depression							INTERVAL BETWEEN ONSET AND DEATH 30 minutes		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Massive Intracerebral Hemorrhage							1 week		
DUE TO (c) Rupture of Berry Aneurysm							1 week		
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.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year							
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	
21. I attended the deceased from Nov 29, 1959 to Dec 5, 1959 and last saw ^{her} him alive on Dec 5, 1959 Death occurred at 12:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Herbert J. Jones R.O.				22b. ADDRESS 926 E. 11th St.				22c. DATE SIGNED 12-6-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 12/6/59	23c. NAME OF CEMETERY OR CREMATORY BERRY PATCH		23d. LOCATION (City, town, or county) (State) CAMEO WEST, VIRGINIA				
24. FUNERAL DIRECTOR C.H. BLACKMAN & SON, INC. K.C. Mo.				25. DATE RECD. BY LOCAL REG. 12-6-59		26. REGISTRAR'S SIGNATURE never minshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

W.C. Quinn

Licensed Embalmer No. 4879

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.