

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010147

FILED VS APR 5 1960

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 94 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u> Length of stay in 1b <u>7 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FULTON STATE HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u> c. CITY OR TOWN <u>WASHINGTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>238 HIGH ST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHANNA</u> Middle <u>WALDEN</u> Last <u>WALDEN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1980</u>	9. AGE (last birthday) <u>80 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (City and state of country) <u>PACIFIC, MISSOURI</u>			
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>PATRICK O'CONNEL</u>		13b. MOTHER'S MAIDEN NAME <u>MARY BRIDGET McNAMEE</u>			
14. NAME OF HUSBAND OR WIFE <u>MATHEN WALDEN</u>		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>D.K.</u>			
17. INFORMANT <u>D.K. Mrs. Patricia Steinhaus - same as deceased</u>		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>GEN. ARTERIOSCLEROSIS & THROMBOSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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 checked="" 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 <u>Feb. 9, 1963</u> to <u>Mar. 27, 1960</u> and last saw her alive on <u>Mar. 27, 1960</u> Death occurred at <u>Fulton State Hosp. 615 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. G. Freund M.D.</u>			22b. ADDRESS <u>Fulton State Hosp.</u>		22c. DATE SIGNED <u>3/27/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>30 March 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick</u>		23d. LOCATION (City, town, or county) (State) <u>CATAWISSA MO.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wallace Funeral Home, Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>March 27-1960</u>		26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

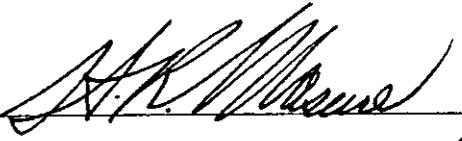
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STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 4996
P. O. Address Fulton, Md

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