

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-029496**

FILED VS. REG. 1 8 1960

Primary Registration District No. 480 Registrar's No. 263

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Adair</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Adair</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Novinger</b>		Length of stay in 1b <b>5 years</b>	c. CITY OR TOWN <b>Novinger</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home in Novinger</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>No street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anderson</b> Middle ----- Last <b>Walker</b>			4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/1870</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General farming</b>	11. BIRTHPLACE (City and state or country) <b>Cock County, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Don't know</b>		13b. MOTHER'S MAIDEN NAME <b>DON'T KNOW</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Frances Walker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Charles Sandstrom, Novinger, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of large Intestines</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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.)		
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 checked="" 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 <b>May 1960</b> , to <b>Aug 31-1960</b> last saw him alive on <b>Aug 30-1960</b> Death occurred at <b>Aug 30 1960 - 12:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. T. Garrison</b> (Degree or title)		22b. ADDRESS <b>Novinger Mo</b>		22c. DATE SIGNED <b>8-31-60</b>	
22d. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22e. DATE <b>9/2/1960</b>		22f. NAME OF CEMETERY OR CREMATORY <b>Cox Cemetery</b>	
22g. LOCATION (City, town, or county) <b>Adair County, Mo.</b>		22h. FUNERAL DIRECTOR <b>Ann E. Felt &amp; Son, Green City, Mo.</b>		22i. ADDRESS <b>Green City, Mo.</b>	
22j. DATE RECD. BY LOCAL REG. <b>9-6-60</b>		22k. REGISTRAR'S SIGNATURE <b>Doris W. Rathoff</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H. T. GARRISON, M.D.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City

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.