

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034487

Dr. Delzell

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1021

FILED VS OCT 17 1960

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DAVIS REST HOME			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1023 W. LYNN		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SARAH Middle E. Last WALTERS			4. DATE OF DEATH Month OCT. Day 7 Year 1960				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/66	9. AGE (last birthday) 93	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) HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) LACLEDE, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN L. REYNOLDS			13b. MOTHER'S MAIDEN NAME MARY SEEDS		14. NAME OF HUSBAND OR WIFE CALVIN WALTERS (DEC.)		
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. NO		17. INFORMANT WM. R. WALTERS, MINNEAPOLIS, MINN.			
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><i>a cute Cardiac Failure</i></u> DUE TO (b) <u><i>Arteriosclerosis + age</i></u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 <u><i>aug 30/60</i></u> , to <u><i>oct 7/60</i></u> and last saw her/him alive on <u><i>oct 7/60</i></u> Death occurred at <u><i>11:30 A.M.</i></u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u><i>W. A. Delzell MD</i></u> (Degree or title)			22b. ADDRESS <u><i>Springfield Mo</i></u>			22c. DATE SIGNED <u><i>10/10/60</i></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/11/60	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.		
24. FUNERAL DIRECTOR H. H. LOHMEYER FUNERAL HOME ADDRESS SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. <u><i>10-11-60</i></u>		26. REGISTRAR'S SIGNATURE <u><i>Effie G. Melton</i></u>		

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. J. McCann*

Licensed Embalmer No. 272

P. O. Address *Springfield*

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