MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-000568
STATE FILE NUMBER

FILED VS JAN 30 1961

AMENDED

Registration District No. 55 Primary Registration District No. 2011 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Carrollton
Length of stay in 1b: 5 weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Atwood Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Carroll
c. CITY OR TOWN: Bogard
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): R70 3
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Frances Middle: M. Last: Walker
4. DATE OF DEATH: Month: January Day: 24 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Nov 13 1900
9. AGE (last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping
11. BIRTHPLACE (City and state or country): Bogard, Mo.
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: O. R. Roberts
13b. MOTHER'S MAIDEN NAME: Nora Graham
14. NAME OF HUSBAND OR WIFE: C. W. Walker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: C. W. Walker, R.F.D. 3 Bogard Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Rt Breast removed 1956
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 yr
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1956, to Jan. 24, 1961 and last saw her/him alive on Jan 24, 1961
Death occurred at 11:00 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John H. Platz (Degree or title): MD
22b. ADDRESS: Carrollton, Missouri
22c. DATE SIGNED: 1-23-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan 26, 1961
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Vaughn Cemetery
23d. LOCATION (City, town, or county) (State): Bogard, Missouri

24. FUNERAL DIRECTOR: Dickerson Funeral Home ADDRESS: Bogard, Mo
25. DATE RECD. BY LOCAL REG.: 1-24-61
26. REGISTRAR'S SIGNATURE: Mrs Verkes Calvert

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

WRITE STUB

0
59
6,

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_____ Signed Samuel M Kim

Signature of Student Embalmer

Licensed Embalmer No. 5087

P. O. Address Bogard, 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.