

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006103

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 39

AMENDED

FILED VS FEB 23 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		c. CITY OR TOWN <u>High Gate, Mo.</u>	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McFarland Nursing Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>L</u> Last <u>Francis</u>			4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u> </u> Min. <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Osage Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Single</u>
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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>None</u>	17. INFORMANT <u>Boyd Cox, High Gate, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>yes.</u>
IMMEDIATE CAUSE (a) <u>For advanced arterio-sclerosis</u>		
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) <u>Prostatic Hypertrophy</u>	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
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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.) <u> </u>
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from 11-4-60 to 2/15/61 and last saw <sup>her</sup>him alive on 2/13/61  
Death occurred at   A   m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James M. Myers MD</u>	(Degree or title)	22b. ADDRESS <u>Rolla, Mo</u>	22c. DATE SIGNED <u>2/6/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/16/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Gate Baptist Cem.</u>	23d. LOCATION (City, town, or county) <u>Maries Co., Missouri</u>
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24. FUNERAL DIRECTOR <u>Jeese Barb St. James, Mo.</u>	ADDRESS <u>200th Melrose</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 16, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Nadine L Stoll</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 C. Jesse Gohs

Licensed Embalmer No. 4486

P. O. Address H. James, M.

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.