ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-012497
STATE FILE NUMBER

AMENDED

Registration District No. 10 Primary Registration District No. 5033 Registrar's No. 70

FILED APR 18 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY AUDRAIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Martinsburg Loutre twp.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RR #1
Inside Limits Yes ☐ No ☒

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

3. NAME OF DECEASED (Type or print) First JOSEPH Middle Last WALKER
4. DATE OF DEATH Month Day Year April 12, 1961
5. SEX male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Apr. 24, 1909
9. AGE (last birthday) 51
IF UNDER 1 YEAR: Months 11 Days 18 Hours Min.
IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer
10b. KIND OF BUSINESS OR INDUSTRY general farming
11. BIRTHPLACE (City and state or country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME Joseph Walker
13b. MOTHER'S MAIDEN NAME Barbara Miller
14. NAME OF HUSBAND OR WIFE Grace Walker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
17. INFORMANT Address Mrs. Grace Walker, St. Louis, Mo

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) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 5 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Diabetes Mellitus — 1 yrs
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. ☐ 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 Dec 1960 to April 1961 and last saw her/him alive on March 15 1961
Death occurred at 4:00 PM 4-12-61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [illegible] MD (Degree or title)
22b. ADDRESS Mexico Mo
22c. DATE SIGNED 4-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Apr. 15 1961
23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Mo
24. FUNERAL DIRECTOR ADDRESS Howard F. Myers, Wellsville, Mo
25. DATE RECD. BY LOCAL REG. April 13 1961
26. REGISTRAR'S SIGNATURE Blanche Neely

(Licensed Embalmer's Statement on Reverse Side)

APR 19 1967

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 Howard F Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville, 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.