

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-035407

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2569

FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Valley Park</u>		Length of stay in 1b <u>13 mo.</u>		c. CITY OR TOWN <u>Gray Summit</u>		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>Valley Park Nursing Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Valley Park Nursing Home</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Livingston Omohundro</u>				4. DATE OF DEATH Month Day Year <u>Sept 10 1961</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w.</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8, 1896</u>	
9. AGE (last birthday) <u>84</u>		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) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			11. BIRTHPLACE (City and state or country) <u>Villa Ridge Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
13a. FATHER'S NAME <u>Robt L. Omohundro</u>				13b. MOTHER'S MAIDEN NAME <u>Martha Ellen Triplett</u>			
14. NAME OF HUSBAND OR WIFE <u>Milford Omohundro, Pacific, Mo.</u>							
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>Milford Omohundro, Pacific, Mo.</u>				Address			
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>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> DUE TO (b) _____ DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <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	
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"/>		20. 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>Sept. 19, 1960</u> to <u>Sept. 10, 1961</u> and last saw ^{her} him alive on <u>Sept. 7, 1961</u> Death occurred at <u>605-A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robt L. Omohundro, M.D.</u>				22b. ADDRESS <u>1502 Cara Av., St Louis</u>		22c. DATE SIGNED <u>9-11-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept 12 '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brush Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Gray Summit Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. John L. Hughes</u>				ADDRESS <u>Pacific Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-12-61</u>	
26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>							

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Joseph Altman

Licensed Embalmer No. 4808

P. O. Address Union, 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.