

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014400

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5161 Registrar's No. 3

FILED MAY 1 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

10140

20140

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94201

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Bloomfield</u>		Length of stay in 1b <u>11 yrs</u>	c. CITY OR TOWN <u>New Bloomfield</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 mi West New Bloomfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Edward Walsh</u>			4. DATE OF DEATH Month Day Year <u>APRIL 23 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Hosp Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (last birthday) Months Days Hours Min. <u>66 8 11</u>
11a. FATHER'S NAME <u>William Walsh</u>		11b. MOTHER'S MAIDEN NAME <u>Jessie Bohymer</u>	11. BIRTHPLACE (City and state or country) <u>Versailles Illinois</u>
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		13. NAME OF HUSBAND OR WIFE <u>Ollie Walsh</u>	
14. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cornary arteriosclerosis: generalized arteriosclerosis with history cerebral hemorrhage 1961</u> DUE TO (c) _____		14. NAME OF HUSBAND OR WIFE <u>MRS. Dan. Walsh</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Myocarditis Chronic</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 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 <u>12 Feb 62</u>		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>7:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D. R. [Signature]</u>		22b. ADDRESS <u>Interton, Mo</u>	22c. DATE SIGNED <u>4 April 62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 25 62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Bloomfield MO</u>
24. FUNERAL DIRECTOR <u>Claypool Ser. New Bloomfield</u>		25. DATE RECD. BY LOCAL REG. <u>Apr 23 1962</u>	26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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 LeRoy Clapp

Licensed Embalmer No. 4412

P. O. Address New Bloomfield IN

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.