

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043327

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 182

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 13 1962	
1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mount Vernon</u> Length of stay in 1b <u>5 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri State Sanatorium</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u> c. CITY OR TOWN <u>Mexico</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>125 S. Kentucky</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>Christine Sophia Walker</u>	
4. DATE OF DEATH Month Day Year <u>December 4 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-17-99</u>
9. AGE (last birthday) <u>63</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>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <u>Illinois U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>J.P. Albright</u>	13b. MOTHER'S MAIDEN NAME <u>Estella Daniel</u>
14. NAME OF HUSBAND OR WIFE	
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 Address <u>Missouri State San., Mt. Vernon, Mo.</u>
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>Far-advanced, active, pulmonary tuberculosis</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>Diabetes Mellitus, severe, with uremia due to neoprosclerosis</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>11-29-62</u> to <u>12-4-62</u> and last saw her him alive on <u>12-4-62</u> Death occurred at <u>8:50</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>J. Lewis Gates, M.D.</u>	
22b. ADDRESS <u>Mo. State San., Mt. Vernon, Mo.</u>	
22c. DATE SIGNED <u>12-4-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-5-62</u>	23b. DATE <u>12-5-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Memorial Park Mexico</u>	
23d. LOCATION (City, town, or county) (State) <u>Mexico Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Arnold Funeral Home Mexico, Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>12-6-62</u>	
26. REGISTRAR'S SIGNATURE <u>Joy Gantman/RS</u>	

VS 300 Rev. 4/59
10550
20047x
3
4 1
5 2
6
7 1
8 2
9002.1
10
11
1293-0
135-0

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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 Max T. Fossett

Licensed Embalmer No. 4252

P. O. Address W. Vernon, 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.