

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

- 4 5 6 7 8 9 10

DO NOT WRITE ON THIS STUB

AMENDED

DEFILED 15 64

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 10044065 STATE FILE NUMBER

VS 300
Rev. 4/59

1 0275
2 0270
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4 0
5 2
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7 0
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12 1-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Length of stay in 1b <u>4 weeks</u>	c. CITY OR TOWN <u>Pilot Grove</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>St. Joseph Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR #</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN - ELSWORTH - WALKER</u>			4. DATE OF DEATH Month Day Year <u>Dec. 3, 1964</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</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>Sept. 22, 1881</u>
9. AGE (last birthday) <u>83</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTH PLACE (City and state or country) <u>Pilot Grove, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank Waller</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Richey</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Waller</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>no</u>	
17. INFORMANT <u>Eugene Waller Nelson</u>		Address <u>no</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>Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>± 3 years</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>Benign Prostatic Hypertrophy with azotemia</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"/>	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 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>11/7/64</u> to <u>12/3/64</u> and last saw her/him alive on <u>12/3/64</u> Death occurred at <u>7:10 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. M. Hays</u> M. D.		22b. ADDRESS <u>329 Main, Boonville, Mo.</u>	22c. DATE SIGNED <u>12/7/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/5/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pilot Grove Ceme</u>	23d. LOCATION (City, town, or county) (State) <u>Pilot Grove, Mo</u>
24. FUNERAL DIRECTOR <u>HAYS & PAINTER</u> ADDRESS <u>PILOT GROVE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>12/7/64</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

DECEASED

DECEASED

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1220

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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 Robert L. Painter

Licensed Embalmer No. 4069

P. O. Address Pilot Grove, 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.