

FILED NOV 21 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **398**

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 1 **2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year  
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson **14**

(c) City or town Kansas City **2**  
(If outside city or town limits, write "RURAL")

(d) Street No. 761 Wornall Road  
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No) **0**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY ELIZABETH WALTON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8  
year 1947 hour 10 minute 47 M.

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: D.K.  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-1-47, 19\_\_\_\_, to 11-8-47, 19\_\_\_\_;  
that I last saw h. EQ alive on 11-8-47, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
Bronchopneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ **107**

Of autopsy \_\_\_\_\_

9. Birthplace D.K. **9**  
(City, town, or county) (State or foreign country)

10. Usual occupation D.K.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name D.K. **9**

13. Birthplace D.K. **9**  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ **9**

15. Birthplace \_\_\_\_\_ **9**  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Hospital Records

(b) Address Fulton Mo.

17. (a) Burial (b) Date thereof Nov. 11, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Acurene, Kansas

18. (a) Signature of funeral director Glen G. Marpin

(b) Address 912 Cant Fulton Mo.

19. (a) Nov. 10-47 (b) Joseph Moravick  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature R.P. Rice M.D. (M. D. or other) **0**

Address Fulton Mo. Date signed 11-10-47  
by H. F. Mayo M.D.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Filed 11-21-47

District File Number

District Health Officer No. 9,

RECEIVED

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Glen J. Maupin

Licensed Embalmer No. 2725

P. O. Address Fulton, 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 this body is not embalmed, fact should be so stated above.