

FILED MAY 14 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11678  
Registrar's No. 501

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

|                                                                                                |  |                                                                                                                                               |  |
|------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u>                                                 |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Kansas</u><br>b. COUNTY <u>Doniphan</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> |  | c. LENGTH OF STAY (In this place) <u>5 days</u>                                                                                               |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Meth. Hospital</u>                         |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Highland</u>                                                  |  |
|                                                                                                |  | d. STREET ADDRESS (If rural, give location)                                                                                                   |  |

|                                     |              |               |                |                                       |
|-------------------------------------|--------------|---------------|----------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First)   | b. (Middle)   | c. (Last)      | 4. DATE OF DEATH (Month) (Day) (Year) |
| <u>Frank Albert Walters</u>         | <u>Frank</u> | <u>Albert</u> | <u>Walters</u> | <u>May 6, 1951</u>                    |

|                                                                                                           |                                                   |                                                                       |                                         |                                            |                 |                  |
|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------|--------------------------------------------|-----------------|------------------|
| 5. SEX <u>male</u>                                                                                        | 6. COLOR OR RACE <u>white</u>                     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Oct. 18, 1875</u>   | 9. AGE (In years) (Month) (Days) <u>75</u> | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 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>own farm</u> | 11. BIRTHPLACE (State or foreign country) <u>Tablegrove, Illinois</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |                                            |                 |                  |

|                                   |                                          |                                                     |
|-----------------------------------|------------------------------------------|-----------------------------------------------------|
| 13a. FATHER'S NAME <u>unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Etta May Walters</u> |
|-----------------------------------|------------------------------------------|-----------------------------------------------------|

|                                                                             |                                                                            |                                                                              |         |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Etta Walters, Highland, Kansas</u> | ADDRESS |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------|---------|

|                                                                                                                                                                                                                                 |                                                                                                                                                                       |  |                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION                                                                                                                                                 |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u><br><br><u>4 years</u> |
|                                                                                                                                                                                                                                 | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>                                                                                     |  |                                                                         |
|                                                                                                                                                                                                                                 | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) |  |                                                                         |
| II. OTHER SIGNIFICANT CONDITIONS:<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                            |                                                                                                                                                                       |  |                                                                         |

|                                 |                                              |                                                                       |
|---------------------------------|----------------------------------------------|-----------------------------------------------------------------------|
| 19a. DATE OF OPERATION <u>0</u> | 19b. MAJOR FINDINGS OF OPERATION <u>331X</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|---------------------------------|----------------------------------------------|-----------------------------------------------------------------------|

|                                                      |                                                                                                        |                                                 |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)             | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                      |

22. I hereby certify that I attended the deceased from 5-1-1951 to 5-6-1951, that I last saw the deceased alive on 5-5-51, 1951, and that death occurred at 12:15A m., from the causes and on the date stated above.

|                                              |                                   |                                |
|----------------------------------------------|-----------------------------------|--------------------------------|
| 23a. SIGNATURE <u>Paul J. Jorgensen M.D.</u> | 23b. ADDRESS <u>St. Joseph Mo</u> | 23c. DATE SIGNED <u>5-7-51</u> |
|----------------------------------------------|-----------------------------------|--------------------------------|

|                                                          |                           |                                    |                                                                       |
|----------------------------------------------------------|---------------------------|------------------------------------|-----------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 24b. DATE <u>5/6/1951</u> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) <u>Highland, Kansas</u> |
|----------------------------------------------------------|---------------------------|------------------------------------|-----------------------------------------------------------------------|

|                                              |                                           |                                                                |                                |
|----------------------------------------------|-------------------------------------------|----------------------------------------------------------------|--------------------------------|
| DATE REC'D BY LOCAL REG. <u>May 11, 1951</u> | REGISTRAR'S SIGNATURE <u>Carl C. East</u> | FUNERAL DIRECTOR'S SIGNATURE <u>Heaton-Bowman Funeral Home</u> | ADDRESS <u>St. Joseph, Mo.</u> |
|----------------------------------------------|-------------------------------------------|----------------------------------------------------------------|--------------------------------|

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

0119

**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 .....  
Student Embalmer

Signed James S. Hawkins

Licensed Embalmer No. 4536

P. O. Address 319 E. 10<sup>th</sup> St. Forest, 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.