

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23333

Registrar's No. 262

BIRTH MO. \_\_\_\_\_ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

485  
0

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>INDEPENDENCE</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>INDEPENDENCE</b> <b>0485</b>	
c. LENGTH OF STAY (In this place) <b>8 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>1500 N. LIBERTY ST.</b> <b>0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VALE SANITARIUM</b>			

3. NAME OF DECEASED a. (First) <b>HARRIET</b> b. (Middle) <b>A.</b> c. (Last) <b>WALL</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 17, 1951</b>		
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5. SEX <b>FE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>FEB. 3, 1867</b>	9. AGE (In years last birthday) <b>84</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 1 HR. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>SALINE COUNTY, MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>RICHARD P. WALL</b>	13b. MOTHER'S MAIDEN NAME <b>AMANDA FOX</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>RICHARD WALL</b> ADDRESS <b>SWEET SPGS MO</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>	<b>a few hrs</b>	
ANTECEDENT CAUSES	Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) <b>General Atherosclerosis</b>	<b>chronic</b>	
	DUE TO (c) <b>Fracture neck right femur</b>	<b>1 day</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331XF</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) <b>accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Vale Sanitarium</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Independence Jackson MO</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>July 16, 1951 - P. m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fall in her room</b>
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22. I hereby certify that I attended the deceased from **June**, 1949, to **July 17, 1951**, that I last saw the deceased alive on **July 16, 1951**, and that death occurred at **a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. H. Hesterion</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Independence MO</b>	23c. DATE SIGNED <b>July 18-51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>7/17/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SWEET SPRINGS CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>SWEET SPRINGS MO</b>
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DATE REC'D BY LOCAL REG. <b>July 17-1951</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>OTT &amp; MITCHELL</b> ADDRESS <b>INDEP. MO.</b>
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AUG 6 1957

SEP 2 1957

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.....

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....

Signed *John Marion Stein*

Licensed Embalmer No. 3156

P. O. Address Independence, 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.