

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29736

FILED OCT 1 1957

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 5224 Registrar's No. 117

1. PLACE OF DEATH
a. COUNTY Cass
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo b. COUNTY Cass

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Grandriver c. LENGTH OF STAY (in this place) 19 yrs
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Grandriver

d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION 1 Mile S.W. of Harrisonville d. STREET ADDRESS (If rural, give location) 1 Mile S.W. of Harrisonville

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) — c. (Last) Todd 4. DATE OF DEATH (Month) (Day) (Year) Sept. 22-1957

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, ~~SEPARATED~~ Married 8. DATE OF BIRTH Feb. 29 1886 9. AGE (In years last birthday) 65 10 UNDER 1 YEAR Months 6 Days 24 10 UNDER 1 WEE Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Farmer retired 5 years 10b. KIND OF BUSINESS OR INDUSTRY 5 years 11. BIRTHPLACE (State or foreign country) Kings Prairie Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Bradford J. Todd 13b. MOTHER'S MAIDEN NAME Mary Taylor 14. NAME OF HUSBAND OR WIFE Lillie E. Todd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Mr. Walter Todd ADDRESS Harrisonville R. 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH Sudden
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Heart Disease
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) Cerebral Arteriosclerosis
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 _____ 20. AUTOPSY? YES NO

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) 4200

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Day 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Aug. 1, 1947, to Sept 22, 1957, that I last saw the deceased alive on Sept 22, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) MD 23b. ADDRESS Harrisonville Mo 23c. DATE SIGNED Sept 24 1957

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Sept 24 1957 24c. NAME OF CEMETERY OR CREMATORY Oakland Cem. 24d. LOCATION (City, town, or county) (State) Harrisonville Mo

DATE REC'D BY LOCAL REG. Sept 24 1957 REGISTRAR'S SIGNATURE [Signature] 4571 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Harrisonville

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

0190



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 Embalmer No.

Signed.....
Student Embalmer

Signed *Hoyd Atkinson*

Licensed Embalmer No. *3920*

P. O. Address *Harrisonville*

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.

Mo.