

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23850**

BIRTH NO. **1111** **AUG 11 1952** REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **243**

0164

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

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jackson	
c. LENGTH OF STAY (In this place) 4 days		d. STREET ADDRESS (If rural, give location) Florence Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Southeast Hospital			
3. NAME OF DECEASED a. (First) Freda b. (Middle) Kurre c. (Last) Walters			4. DATE OF DEATH (Month) (Day) (Year) 8-7-52
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6-11-82
9. AGE (In years of UNDER 1 YEAR Months Days) 70		9. AGE (In years of UNDER 1 YEAR Months Days) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Fred Kurre		13b. MOTHER'S MAIDEN NAME Bast	
14. NAME OF HUSBAND OR WIFE Herman Walters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Faye Prill		ADDRESS Centrellia, Ill	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION 10-22-51		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Colon	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 Aug 21, 1951 , to Aug 7, 1952 , that I last saw the deceased alive on Aug 6, 1952 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE C.F. McDonald MD		23b. ADDRESS Jackson, Mo.	
23c. DATE SIGNED 8-7-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-9-52	
24c. NAME OF CEMETERY OR CREMATORY City Cemetary		24d. LOCATION (City, town, or county) (State) Jackson Mo.	
DATE REC'D BY LOCAL REG. 8-7-52		REGISTRAR'S SIGNATURE C. C. Summers	
25. FUNERAL DIRECTOR'S SIGNATURE M. Camps		ADDRESS Funeral Home, Jackson	

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 _____

Thos K. Allen

Signed.....
Student Embalmer

Licensed Embalmer No. 4056

P. O. Address Jackson

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.