

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34285

State File No. _____
Registrar's No. 1121

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (In this place) 1 yr	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		d. STREET ADDRESS (If rural, give location) 915 Sixth Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) O'Rita	b. (Middle) Maxine	c. (Last) Walters	Oct. 16 1952		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 12 1918	9. AGE (In years last birthday) 34	# UNDER 1 YEAR Months Days	# UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS* OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Grant City Missouri	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Orville Armstrong	13b. MOTHER'S MAIDEN NAME Vesta Warden	14. NAME OF HUSBAND OR WIFE Edward L. Walters
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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. unk.	17. INFORMANT'S SIGNATURE OR NAME Mr. Edward L. Walters	ADDRESS St. Joseph Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Multiple sclerosis</i>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 345 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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 10-10, 1952, to 10-16, 1952, that I last saw the deceased alive on 10-16, 1952, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Orville Armstrong</i>	(Degree or title) M.D.	23b. ADDRESS St. Joseph Mo.	23c. DATE SIGNED 10-17-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 17, 1952	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Grant City Missouri
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DATE REC'D BY LOCAL REG. Oct 25, 1952	REGISTRAR'S SIGNATURE <i>Carl C. Casper</i>	496	25. FUNERAL DIRECTOR'S SIGNATURE <i>Stamery Funeral Home</i>	ADDRESS St. Joseph Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0117

0117

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 Charles E. Bunt.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4677.....

P. O. Address St Joseph 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.