

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34563

State File No. ....

BIRTH NO. 71156-54 REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 171

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>422 Collier St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>GAYLE</u> b. (Middle) <u>ANN</u> c. (Last) <u>WALKER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 16 1954</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>October 15 1954</u>	9. AGE (In years last birthday) <u>1</u> <u>5</u> <u>5</u> If under 1 year: Months <u>1</u> Days <u>5</u> Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Chillicothe, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Forrest Elwood Walker</u>	13b. MOTHER'S MAIDEN NAME <u>Marjorie Lee Mendenhall</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Forrest Elwood Walker; Chillicothe, Mo.</u>	ADDRESS
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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 <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelactasis - Mucus in throat</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Placenta Previa - 7 mo -</u> 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 15 Oct, 1954, to 16 Oct, 1954, that I last saw the deceased alive on 16 Oct, 1954 and that death occurred at 6:25 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>V.D. Vanelsler</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>16 Oct 1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 16 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri (Liv' Co.)</u>
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DATE REC'D BY LOCAL REG. <u>Oct-16-54</u>	REGISTRAR'S SIGNATURE <u>Francis B. Nail</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funeral Home</u>	ADDRESS <u>Chillicothe, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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

*Joseph M. Libson*

Licensed Embalmer No. *4769*

P. O. Address *Chillicothe, 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.