

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 24 1955

BIRTH NO. 211 2605-55 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 581

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas city		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) Life		e. STREET ADDRESS (If rural, give location) 3036 Walrond	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital		3. NAME OF DECEASED a. (First) Infant (Type or Print)	
b. (Middle) -----		c. (Last) Walker	4. DATE OF DEATH (Month) (Day) (Year) January 7, 1955
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH January 7, 1955
9. AGE (In years last birthday) 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Chester Arthur Walker		13b. MOTHER'S MAIDEN NAME Luella Mae Ward	14. NAME OF HUSBAND OR WIFE none
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 Luella Mae Walker
		ADDRESS 3036 Walrond	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Immaturity due to prematurity		DUPLICATE OF (b) Premature separation of placenta		7615
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (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 checked="" type="checkbox"/> NO <input 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) (Min.)	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 1-7-55, 1955, to 1-7-, 1955, that I last saw the deceased alive on 1-7-55, 1955, and that death occurred at 11:25 AM, from the causes and on the date stated above.

23a. SIGNATURE Andre G. Renaud (Degree or title) MD 23b. ADDRESS 2204 E 18th 23c. DATE SIGNED 1/19/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 1-28-55 24c. NAME OF CEMETERY OR CREMATORY Leeds 24d. LOCATION (City, town, or county) (State) Kansas City Mo.

DATE REC'D BY LOCAL REG 2-8-55 REGISTRAR'S SIGNATURE Neve Minshall 25. FUNERAL DIRECTOR'S SIGNATURE Tom A. Johnson ADDRESS 130 E. 11th

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

APR 25 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Not Embalmed Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.