

FILED OCT 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34129**

BIRTH NO. _____ REG. DIST. NO. 231 PRIMARY REG. DIST. NO. 5811 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>P.F.D. MONTGOMERY CITY</u>		c. LENGTH OF STAY (in this place) <u>5 YRS.</u>	c. CITY OR TOWN <u>MONTGOMERY CITY</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MONTGOMERY CITY RR#1</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <u>MONTGOMERY CITY RR#1 0700</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILBERE</u> b. (Middle) <u>E.</u> c. (Last) <u>WALKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-7-55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 6, 1896</u>
9. AGE (In years last birthday) <u>69</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>ADRAIN CO., MO.</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>ADRAIN CO., MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>?? WALKER</u>		13b. MOTHER'S MAIDEN NAME <u>MATTIE ??</u>	14. NAME OF HUSBAND OR WIFE <u>JOSIE WALKER</u>
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>342-03-8475</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. JOSEPHINE WALKER - MONTGOMERY CITY, MO.</u>	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Allergic Dermatitis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 mo's</u> <u>1 month</u> <u>5-10 yrs</u>
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? <u>4201</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>---</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>Sept. 14, 1955</u> , to <u>Oct 7, 1955</u> , that I last saw the deceased alive on <u>Sept. 23, 1955</u> , and that death occurred at <u>8:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E. J. T. Andersen, M.D.</u>		23b. ADDRESS <u>Montgomery City, Mo.</u>	23c. DATE SIGNED <u>10/12/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>10-10-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>HANNIBAL, MO.</u>
DATE REC'D BY LOCAL REG. <u>10-7-1955</u>	REGISTRAR'S SIGNATURE <u>Laura B. Callaway</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frank Schwarz - Hannibal, Mo.</u>	

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

0720

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.....
Signature of Student Embalmer

Signed.....
Jack Schwartz

Licensed Embalmer No.....
490

P. O. Address.....
Herrnstein

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.