

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37562

FILED NOV 16 1956

BIRTH NO. _____		REG. DIST. NO. <u>114</u>		PRIMARY REG. DIST. NO. <u>4186</u>		Registrar's No. <u>47</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sullivan</u>		c. LENGTH OF STAY (in this place) <u>1 yr.</u>		c. CITY OR TOWN <u>Sullivan</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>311 W Springfield</u>				e. STREET ADDRESS (If rural, give location) <u>none</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charley</u> b. (Middle) <u>P</u> c. (Last) <u>Walsh</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 11 1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 22 1877</u>	
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Days <u>8</u>		IF UNDER 1 HR. Hours <u>19</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Oak Ridge Mo.</u>	
13a. FATHER'S NAME <u>John P Walsh</u>			13b. MOTHER'S MAIDEN NAME <u>Cathrin Hines</u>			14. NAME OF HUSBAND OR WIFE <u>Ida Elizabeth Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Maple Walsh Sullivan 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>INTERNAL HEMORRHAGE</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CARCINOMA STOMACH.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ARTEMIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>MONTHS</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>151X</u>			20. AUTOPSY? YES <input 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) 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 <u>April 1955</u> , to <u>Nov 11, 1956</u> , that I last saw the deceased alive on <u>Nov 9, 1956</u> , and that death occurred at <u>8:57 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert J. Thompson M.D.</u>				23b. ADDRESS <u>No. 2 Sullivan Mission</u>		23c. DATE SIGNED <u>Nov 12 1956</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov 15 56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Schmidt</u>		24d. LOCATION (City, town, or county) (State) <u>Strain Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-14-56</u>		REGISTRAR'S SIGNATURE <u>Thomas G. Humphrey</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rev. P. Thayer Hallum</u>		

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

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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 *Pho. P. Shaffer*.....

Licensed Embalmer No. *2692*.....

P. O. Address *Lullena*.....

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.