

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38377

STATE FILE NUMBER

FILED DEC 13 1956

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 551

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3210 Blue Ridge</b>			Length of stay in lb <b>4 years</b>		d. STREET ADDRESS (If outside, give location) <b>3210 Blue Ridge</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>L.</b> Last <b>WALTERS</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>2</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1889</b>		9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Iuka Springs, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Walters</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice McNutt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-01-9657</b>		17. INFORMANT <b>Phillip L. Walters Kansas City, Kansas</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Coronary</b> DUE TO (b) <b>arterio sclerotic heart disease</b> DUE TO (c) <b>H2O.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>4 years</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>-</b> Month <b>-</b> Day <b>-</b> Year <b>-</b> a. m. <b>-</b> p. m. <b>-</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>9-23-56</b> to <b>12-2-56</b> and last saw her alive on <b>8-23-56</b> . Death occurred at <b>12:30 P. m</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or print) <b>Phillip L. Walters MD</b>				22b. ADDRESS <b>9109 E new 40 Indp Mo</b>		22c. DATE SIGNED <b>12-3-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 5, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Washington Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons Independence, Mo.</b>				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <b>James H. Craig</b>	

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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 em  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Tom D Markland*

Licensed Embalmer No. *45*

P. O. Address *Indep*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.