

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

16499

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3017 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u>	c. LENGTH OF STAY (in this place) <u>23 YRS</u>	c. CITY OR TOWN <u>Excelsior Springs</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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>114 Tarriss St.</u>		STREET ADDRESS (If rural give location) <u>114 Tarriss St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ERNEST</u> b. (Middle) <u>W.</u> c. (Last) <u>WALL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 20 - 1957</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-19-1884</u>	9. AGE (in years last birthday) <u>72</u> IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vendor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Gardening</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Clark, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William A. Wall</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Nettie M. Wall</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>513-14-1349</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Nettie Wall</u>	ADDRESS <u>114 Tarriss, Exc. Springs, Mo.</u>
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Failure Pulmonary Edema</u>	DUPLICATE	<u>4 hrs</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUPLICATE	<u>Chronic Myocardial Infarction</u>	<u>8 mo.</u>
DUPLICATE	DUPLICATE	<u>Chronic Bihypertensive Hypertension</u>	<u>6 yrs.</u>
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 <u>4201</u>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) <u>Excelsior Springs, Clay, Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 1950 to 4/20, 1957 that I last saw the deceased alive on 4/20, 1957, and that death occurred at 12:45 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Clara E. Buchner, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Lansdown Mo</u>	23c. DATE SIGNED <u>4/20/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-23-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Clark, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>5/1/57</u>	REGISTRAR'S SIGNATURE <u>Caroline Kutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Prichard Funeral Home, Inc.</u>	ADDRESS <u>Excelsior Springs, Missouri</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

62-



AUG 2 6 1958

MAY 23 1958

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.....

Lindell K. Jarmann

Licensed Embalmer No. 458

Excelsior Springs,
P. O. Address

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.