

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20546

STATE FILE NUMBER

FILED JUL 9 1957

Registration District No. 96 Primary Registration District No. 4158 Registrar's No. 60

Health, Welfare Public Service

300 4
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, give address before admission) a. STATE <u>MO.</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buffalo</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural - Green</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Marshall Rest Home</u> Length of stay, in 1b <u>12 days</u>		d. STREET ADDRESS (If outside, give location) <u>0840</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>Walker</u> Last <u>Walker</u>			4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>57</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 - 1876</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR: Months <u>7</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (City and state or country) <u>Hickory Co, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>W. H. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Schott Anderson</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>No</u>	
17. INFORMANT <u>OPal Lewis</u>		Address <u>Wichite Mox</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Nephrosis</u> DUE TO (c) <u>Prostatic Hypertrophy and Urethrocystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 months</u> <u>12 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		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 <u></u> Month, Day, Year <u></u> a. m. <u></u> p. m. <u></u>	
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 <u>6-7-57</u> to <u>6-17-57</u> and last saw <u>him</u> alive on <u>6-17-57</u> Death occurred at <u>3:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. B. Bennett</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Buffalo, Missouri</u>	
22c. DATE SIGNED <u>6-22-57</u>		23a. LOCAL CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>6-30-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge</u>	
23d. LOCATION (City, town, or county) <u>Hickory Co, MO</u>		(State)	
24. FUNERAL DIRECTOR <u>Allen W. Vaughan</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7/8/57</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Grace Petre</u>		(Licensed Embalmer's Statement on Reverse Side)	

MEDICAL CERTIFICATION

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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 *Allen W. Saughan*

Licensed Embalmer No. *412*

P. O. Address *Urbana*

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.