

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **2424**

FILED FEB 10 1958

Registration District No. **294** Primary Registration District No. **3056** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo. b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN Moberly Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Jacksonville 288⁰ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 601 Fulton		d. STREET ADDRESS RR #2 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle BELLE Last WALKER		4. DATE OF DEATH Month Jan Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25-1891
9. AGE (In years, tag birthday) 66		IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) Randolph Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Perkins	
14. MOTHER'S MAIDEN NAME Carrie Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address 331X H	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage		12 days
DUE TO (c) Arteriosclerosis		Centurion
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca. Rb Breast		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.) 331X H	
20c. TIME OF INJURY Hour — Month — Day — Year — a. m. — p. m. —		
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 TOWNSHIP COUNTY STATE

21. I attended the deceased from **Aug - 57** to **1-24-58** and last saw her ^{him} alive on **1-24-58**
Death occurred at **2:15** p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **H. C. Kelley D.O.** 22b. ADDRESS **Moberly, Mo** 22c. DATE SIGNED **1-25-58**

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 26-1958	23c. NAME OF CEMETERY OR CREMATORY Smoot Gardens	23d. LOCATION (City, town, or county) (State) Moberly Missouri
24. FUNERAL DIRECTOR ADDRESS Cater Funeral Home Moberly Mo	25. DATE RECD. BY LOCAL REG. 1-25-58	26. REGISTRAR'S SIGNATURE Leah Lawrence	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
 300 1-56
 Director, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....
Licensed Embalmer No. 11900

P. O. Address.....
Moberly, Mo.

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.