

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

66298 37  
58-014515  
STATE FILE NUMBER

FILED MAY 9 1958

1973 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2010

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5623 ANDERSON		d. STREET ADDRESS (If outside, give location) 5623 ANDERSON	
3. NAME OF DECEASED (Type or print) First Middle Last SHERRY LYNN WALKER		4. DATE OF DEATH Month Day Year 4 18 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Earl R. Walker Jr.		13b. MOTHER'S MAIDEN NAME Patricia Booth	14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Earl R. Walker, 5623 ANDERSON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningoencephalitis DUE TO (b) _____ DUE TO (c) _____ 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  0571
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>W.C. Kealhofer, M.D.</i>		22b. ADDRESS 6027 Reslett's Court	22c. DATE SIGNED 4-18-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/21/58	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR ADDRESS Skeil Funeral Home K.C. Mo		25. DATE RECD. BY LOCAL REG. 4-19-58	26. REGISTRAR'S SIGNATURE <i>Neve Minshall</i>

5. 300  
1-57

All diseases in Part I must be causally related.  
Geo. C. Kealhofer

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Richard E. Carroll* .....

Licensed Embalmer No. *4829* .....

P. O. Address *R. E. S. Co.* .....

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.