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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-039284
STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 146

1. PLACE OF DEATH
a. COUNTY Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Smithville — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Smithville Hospital — Length of stay in 1b 3 mos.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Clay
c. CITY OR TOWN Excelsior Springs 6002 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 427 Kimball — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Catherine Middle Last Walsh

4. DATE OF DEATH Month Day Year Nov. 15, 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH April 1, 1874
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) Simpson, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Timothy Twohey
13b. MOTHER'S MAIDEN NAME Susan McGovern
14. NAME OF HUSBAND OR WIFE Patrick Walsh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Norman McCrorey, Address 427 Kimball Ex. Springs, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Gangrene of Right leg requiring amputation
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 8-14-58, to 11-15-58 and last saw her/him alive on 11-15-58
Death occurred at 3:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of title) Paul C Vescovo Jr. M.D.
22b. ADDRESS Smithville Missouri
22c. DATE SIGNED 11-15-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-15-58
23c. NAME OF CEMETERY OR CREMATORY Calvary Cem, Rochester, Minn.
23d. LOCATION (City, town, or county) (State) Excelsior Springs, Mo.

24. FUNERAL DIRECTOR ADDRESS Prichard Funeral Home, Inc. Excelsior Springs, Missouri
25. DATE RECD. BY LOCAL REG. 11-15-58
26. REGISTRAR'S SIGNATURE Marguerite Hudgens

(Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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RECEIVED
CLAY CO.
HEALTH CENTER

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 R. Jacoman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, Mo.

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.