

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006143

STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 155 Primary Registration District No. 5579 Registrar's No. 30

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1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City, Mo. MINERAL Length of stay in lb Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ⁶⁴⁹⁶ Duenweg, Missouri ⁰ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elmhurst		d. STREET ADDRESS (If outside, give location) 2 Miles East Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle D. Last Walthall		4. DATE OF DEATH Month Feb. Day 15, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1875
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Duenweg, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME W.L. Scott	
14. MOTHER'S MAIDEN NAME Eliza Mayberry		15. NAME OF HUSBAND OR WIFE	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 331X	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSION DUE TO (c) ARTERIO-SCLEROSIS		19. INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 1956 to 2-15-59 and last saw her alive on 2-15-59 Death occurred at 10:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE P.M. Pence (Degree or title) D.O.	
22b. ADDRESS Carterville, Mo.		22c. DATE SIGNED 2-19-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-18-1959	23c. NAME OF CEMETERY OR CREMATORY Forrest Park Cemetery	23d. LOCATION (City, town, or country) (State) Joplin Mo.
24. FUNERAL DIRECTOR Johnston-Arnice-Simpson Mortuary Webb City, Mo.		25. DATE RECD. BY LOCAL REG. 2-19-59	26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer

MEDICAL CERTIFICATION ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *Clayton M. Johnson*

Licensed Embalmer No. *4304*

P. O. Address. *Webb City*

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.