

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009723

STATE FILE NUMBER 1170

FILED MAR 19 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansaa City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Length of stay in 1b <b>7 years</b>	d. STREET ADDRESS (If outside, give location) <b>1305 E. 82nd Terr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>H.</b> Last <b>Walton</b>			4. DATE OF DEATH Month <b>2nd</b> Day <b>28th</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-84</b>	9. AGE (In years last birthday) <b>74 yrs</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. TYPE OF OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	11. BIRTHPLACE (City and state or country) <b>Beloit, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Wellington J. Walton</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Conklin</b>		14. NAME OF HUSBAND OR WIFE <b>Marion J. Walton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>364-61-8485</b>	17. INFORMANT Address <b>V.A. Hospital Records, K.C., Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion and edema</b>					INTERVAL BETWEEN ONSET AND DEATH <b>154</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Upper G.I. tract obstruction</b>					
DUE TO (c) <b>Carcinoma of the rectum, recurrent</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary emphysema</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <b>September 15, 1958</b> to <b>February 28, 1959</b> as follows: Death occurred at <b>1:25 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>J.H. Turner MD</b>			22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>2-28-59</b>
23a. BURIAL CREMATION, RECOVERY (Specify) <b>BURIAL</b>		23b. DATE <b>MARCH 4, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>	
				23d. LOCATION (City, town, or county) (State) <b>FT. LEAVENWORTH KANSAS</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>			25. DATE RECD. BY LOCAL REG. <b>3-3-59</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. A. Turner

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 *Chester K. Brown* .....

Licensed Embalmer No. *493* .....

P. O. Address *KO 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.