

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017284
STATE FILE NUMBER

FILED JUN 2 1959 Registration District No. 111 Primary Registration District No. 4183 Registrar's No. 21

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pacific, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Labadie</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hogan Sub Division</u>		Length of stay in lb <u>5 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>360</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>N.</u> Last <u>Walter</u>			4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21, 1900</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Trade</u>	11. BIRTHPLACE (City and state or country) <u>Labadie, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Charles Walter</u>		13b. MOTHER'S MAIDEN NAME <u>Alwine Thibes</u>		14. NAME OF HUSBAND OR WIFE <u>Marie M. Walter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>493-01-5346</u>	17. INFORMANT <u>Marie M. Walter, Labadie, Missouri</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, due to arterio-sclerotic thrombosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arterio-sclerotic heart disease, with infarction of myocardium</u>		<u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 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 5/20/59 to 5/28/59 and last saw ^{them} _{him} alive on 5/16/59
Death occurred at 12:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Michael A. Keffner, M.D.</u> (Degree or title)	22b. ADDRESS <u>10nd. & Elm Sts. Washington, Mo</u>	22c. DATE SIGNED <u>May 29, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 31, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>
24. FUNERAL DIRECTOR <u>Nieburg & Witt, Inc.</u>	ADDRESS <u>Washington, Mo</u>	25. DATE RECD. OF LOCAL REG. <u>May 30, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mary B. Gross</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Lester H. Pitt*

Licensed Embalmer No. *3254*
P. O. Address *Washington, D.C.*

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.