

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022034

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 54

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lefayette</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>Lefayette</u>)	
b. CITY OR TOWN <u>Lefington mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lefington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>116 So. 8th</u> Length of stay in <u>31 day</u>		d. STREET ADDRESS <u>116 So 8th St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSIE MAXINE WALTON</u>			4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1928</u>
9. AGE (In years - Last birthday) <u>31</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>	11. BIRTHPLACE (City and state or country) <u>Lefington mo</u>
10a. FATHER'S NAME <u>Douglas Walton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. MOTHER'S MAIDEN NAME <u>Agnes O. Washington</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Agnes O. Washington</u> Address <u>Lefington, Miss</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>Acute Myocardial Regeneration & Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute pulmonary Edema.</u>			<u>10 hr</u>
DUE TO (c) <u>Chronic pneumonia.</u>			<u>2520 14 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Grav. Hypothyroidism 4 months.</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 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 <u>May 18 1959</u> to <u>May 24 1959</u> and last saw her alive on <u>May 24, 1959</u> Death occurred at <u>11:50 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. John C. Calton Do</u>		22b. ADDRESS <u>1114 1/2 main Leavenworth mo</u>	22c. DATE SIGNED <u>5/26/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>May 28 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wellington Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wellington mo.</u>
24. FUNERAL DIRECTOR <u>George A. Green</u> ADDRESS <u>Marshall Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-3-59</u>	26. REGISTRAR'S SIGNATURE <u>Wm. E. Eastburn</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

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 *Gregory H. Green*

Licensed Embalmer No. *4220*

P. O. Address *Marshall 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.