

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032638

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4322 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>9 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>QUEEN OF THE WORLD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3526 CLEVELAND</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Michael</u> Middle Last <u>WALTON</u>			<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>4</u> Year <u>59</u>				
<b>5. SEX</b> <u>BOY</u>	<b>6. COLOR OR RACE</b> <u>NEGRO</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-26-59</u>	<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR Months <u>9</u> Days IF UNDER 24 HR Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>infant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>KANSAS CITY, MO.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>William WALTON</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>LINDA HUTCHINS</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>none</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Linda Walton 3526 CLEVELAND K.C.MO.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY STATE			
<b>21. I attended the deceased from</b> <u>8-26-59</u> to <u>9-4-59</u> and last saw her/him alive on <u>9-4-59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Starks J. Williams, M.D.</u>			<b>22b. ADDRESS</b> <u>Queen of World Hospital</u>		<b>22c. DATE SIGNED</b> <u>9-5-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>9/5/59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Lane</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>K.C. Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Ch. David K.C. Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-5-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Minshall</u>		

DOCUMENT

BY AFFIDAVIT OF

STARKS J. WILLIAMS, M.D. 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl David

Licensed Embalmer No. 441  
P. O. Address 79-5220

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.