

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 20 1959

59-036970

Registration District No. 234 Primary Registration District No. 5815 Registrar's No. 15

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Haw Creek Township</u>		Length of stay in 1b <u>1 yr.</u>	c. CITY OR TOWN <u>Windsor</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 M.N.W. Versailles</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Johnson</u> Last <u>Walkup</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>6.</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1872</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Decatur, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>No Record</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>Charles C. Walkup</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>Unknown</u>	17. INFORMANT Address <u>Mrs Edison Ball Versailles, Mo.</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>Bronchopneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 weeks</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral thrombosis</u>					<u>2 weeks</u>	
DUE TO (c) <u>Advanced arteriosclerosis</u>					<u>many years</u>	
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	
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 a.m. p.m. Month, Day, Year						
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 <u>Jan 1959</u> to <u>Oct 6 1959</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>Oct 6 1959</u> Death occurred at <u>8:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Deceased or title) <u>Jack Gunn MD</u>			22b. ADDRESS <u>Versailles, Mo</u>		22c. DATE SIGNED <u>10.6.59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S Laurel Oak Cemetery</u>		23d. LOCATION (City, town, or county) <u>Windsor, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>Huston Funeral Home Windsor, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Oct, 17, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Wm L Ripberger</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 17 1966

**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

*Raymond Lasher*

Licensed Embalmer No. 4626

P. O. Address Versailles, 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.