

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038047

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 282 Primary Registration District No. _____ Registrar's No. 133

STATE FILE NUMBER

AMENDED

FILED NOV 14 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Polk</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Morrisville, Mo</u>	a. STATE <u>Mo</u>	b. COUNTY <u>Polk</u>
Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Morrisville, Mo</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>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <u>Richard</u>	Middle <u>Weldon</u>	Last <u>Walker</u>	4. DATE OF DEATH	Month <u>November</u>	Day <u>9</u>	Year <u>1961</u>
-------------------------------------	-------------------------	-------------------------	-----------------------	------------------	--------------------------	-----------------	---------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Aug 7, 1898</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Polk County</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	---

13a. FATHER'S NAME <u>Weldon Walker</u>	13b. MOTHER'S MAIDEN NAME <u>Apra Belle Box</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>Ray W. Brown</u>	Address <u>Bolivar, Mo</u>
---	--	--------------------------------------	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>presumed to be natural</u>		
DUE TO (b) <u>causes</u>		
DUE TO (c)		
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 _____ to _____ and last saw her/him alive on _____.

Death occurred at 9:00 A. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ralph Gordon</u>	(Degree or title) <u>Registrar Polk Co</u>	22b. ADDRESS <u>Bolivar Mo.</u>	22c. DATE SIGNED <u>Nov 10 61</u>
---------------------------------------	---	------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stagle Cemetery</u>	23d. LOCATION (City, town, or county) <u>South Stagle, Mo</u>
--	------------------------------	--	--

24. FUNERAL DIRECTOR <u>Paul D. Butler</u>	ADDRESS <u>Bolivar, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ralph Gordon per Jewell Gordon</u>
---	-------------------------------	--	--

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BX-AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Paul D Butler

Licensed Embalmer No. 4471

P. O. Address Bolivar, 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.