

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043460

FILED DEC 26 1961

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 369

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 0 yrs		c. CITY OR TOWN Brashear		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Comm. Home # 1			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last MARY ETTIE WALTERS				4. DATE OF DEATH Month Day Year Dec. 16 1961									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/23/79		9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Adair Co., Mo.		12. CITIZEN OF WHAT COUNTRY U S					
13a. FATHER'S NAME Timothy Cusick				13b. MOTHER'S MAIDEN NAME Mary Kephart				14. NAME OF HUSBAND OR WIFE J. A. Walters					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Dora Watson, Kirksville, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cochecia and Inanition DUE TO (b) Cerebral Encephalomalacia DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH weeks months 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 checked="" 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 7-17-61 to 12-16-61 and last saw her ^{her} him alive on 12-16-61 Death occurred at 7:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE George H. Chemen, D.D. (Degree or title)						22b. ADDRESS Kirksville			22c. DATE SIGNED 12-18-61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/18/61		23c. NAME OF CEMETERY OR CREMATORY Brashear			23d. LOCATION (City, town, or county) (State) Brashear, Adair, Mo/						
24. FUNERAL DIRECTOR Foster Memorial Home, Kirksville, Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. 12-18-1961		26. REGISTRAR'S SIGNATURE Dora W. Ratliff							

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

GEORGE H. SCHEURER, D.O.

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 Novak E. Foster

Licensed Embalmer No. 4742

P. O. Address Fuksville, 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.