

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4911-62-035038  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4911

<b>FILED OCT 8 1962</b>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay <u>4 wk</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARKS. HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>	
c. CITY OR TOWN <u>Blue Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS <u>Box 119</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>ELLEN</u> Last <u>WALKER</u>	4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>62</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-84</u>
9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
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 <u>  </u>
11. BIRTHPLACE (City and state or country) <u>Linnwood Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Enoch Vernon</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Guyer</u>
14. NAME OF HUSBAND OR WIFE <u>Sam Walker</u>	17. INFORMANT <u>Sam Walker</u> Address <u>Blue Springs Mo</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
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>Intestinal Obstruction by gallstone</u> INTERVAL BETWEEN ONSET AND DEATH <u>9/2/62</u> DUE TO (b) <u>Cholecystoduodenostomy spontaneous</u> <u>8/28/62</u> DUE TO (c) <u>Acute Cholecystitis</u> <u>4/28/62</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>  </u> Month, Day, Year <u>  </u> p.m. <u>  </u>	
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.) <u>  </u>
20f. CITY, TOWN, OR LOCATION <u>  </u> COUNTY <u>  </u> STATE <u>  </u>	
21. I attended the deceased from <u>4/28/62</u> to <u>9/24/62</u> and last saw her <u>  </u> alive on <u>9/24/62</u> Death occurred at <u>4.A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>G. Leitch M.D.</u>	22b. ADDRESS <u>808 S. 15 Blue Springs Mo</u>
22c. DATE SIGNED <u>9/25/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	23b. DATE <u>9-26-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs</u>	
23d. LOCATION (City, town, or county) <u>Blue Springs Mo</u>	
24. FUNERAL DIRECTOR <u>Mayfield</u> ADDRESS <u>Blue Springs</u>	
25. DATE RECD. BY LOCAL REG. <u>9-25-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

VS 300 Rev. 4/59	
1	
2	<u>17000 X2</u>
3	
4	<u>1</u>
5	<u>1</u>
6	
7	<u>0</u>
8	<u>1</u>
9	<u>584X</u>
10	
11	
12	<u>67-0</u>
13	

**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 Charles E. Mayfield

Licensed Embalmer No. 4638

P. O. Address Blue Springs

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.