WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13014

1. PLACE OF DEATH

County.....

Township.....

City St. Louis (No. 5227 Louisiana av St. ..... Ward)

Registration District No. 791

Primary Registration District No. 1003

File No.....

Registered No. 3302

2. FULL NAME Genevieve M. Walker

(a) Residence. No. 5227 Louisiana St., 15 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Virgil S. Walker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feby. 1-1895

7. AGE: Years 32 | Months 2 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: William J. Hart

11. BIRTHPLACE OF FATHER (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Mo

12. MAIDEN NAME OF MOTHER: Mary R Harrison

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Mo

14. INFORMANT: Virgil S. Walker
(Address): 5227 Louisiana

15. FILED APR -6 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr. 4 1927

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1927, to April 4, 1927, that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 12:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Tuberculosis
23 A
31
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Geo R Richter, M. D

4. 5, 1927 (Address) 3538 Humphrey

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Valhalla cemetery | DATE OF BURIAL: Apr. 6 1927

20. UNDERTAKER: Cullinane Bros | ADDRESS: 1710 N Grand Bl

Dr. Leo Richter
3538 Humphrey
Prospect 1-0 13