

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

Do not use this space.
13027

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.....

Township.....

Primary Registration District No. **1003**

Registered No. **3316**

City **St. Louis, Missouri Isolation Hospital** St. _____ Ward _____

2. FULL NAME

Dorothy Walker (Dorothy Walker)

(a) Residence. No. **3831** **Indiana** St., **24** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **1** yrs. **1** mos. **3** 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) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **single**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 3, 1926**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	1	1	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **nil**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Missouri**
(STATE OR COUNTRY)

10. NAME OF FATHER **Orville Walker**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Mo.**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Ruby Fanning**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Mo.**
(STATE OR COUNTRY)

14. INFORMANT **L. Kerner Isolation Hospital Records**
(Address) **St. Louis, Mo.**

15. FILED **APR -6 1927** **Mar. B. Starckoff**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4 - 4 19 27**

17. I HEREBY CERTIFY, That I attended deceased from **April 3, 1927** to **Apr - 4, 1927**, that I last saw her alive on **Apr 4, 1927**, and that death occurred, on the date stated above, at **7:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Menigitis, Probably Tuberculous
J. B. R. (duration) yrs. mos. **16** ds.

CONTRIBUTORY (SECONDARY) **J. B. R.** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **3831 Indiana**
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? **Chicago -**
(Signed) **George H. Garrison, M.D.**

(Address) **Isolation Hospital**

*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 **St. Johns Cemetery St. Charles Mo** DATE OF BURIAL **4/7 1927**

20. UNDERTAKER **W. A. Stockwell Co** ADDRESS **21176 Grand**

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.

