

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

Do not use this space.

2032

**1. PLACE OF DEATH**

County Macon  
Township Chariton  
City (No. ....) St. .... Ward

Registration District No. 529  
Primary Registration District No. 5705

File No. ....  
Registered No. ....

**2. FULL NAME**

Mary Walker  
(a) Residence No. .... St. .... 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) - - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
75

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) England

PARENTS

10. NAME OF FATHER James Beeler

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

12. MAIDEN NAME OF MOTHER Betsy Coover

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

14. INFORMANT Joseph Walker  
(Address) RA Dr. Bevier Mo

15. FILED ..... 19 .....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1931 to Jan 13 1931, 19 31 that I last saw her alive on Jan 13 1931, 19 31 and that death occurred, on the date stated above, at 10:45 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Angiostenosis  
(duration) 2 yrs. 2 mos. 2 da.

CONTRIBUTORY (SECONDARY) Atherosclerosis  
(duration) 4 yrs. 0 mos. 0 da.

**18. WHERE WAS DISEASE CONTRACTED**

8/15/1931  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) J. M. Bevier, M. D.

1/16 1931 (Address) Macon Mo

\*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 Outloch Cem DATE OF BURIAL Jan 16 1931

20. UNDERTAKER Albert Skinner ADDRESS Macon

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.

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

61  
DEC 30 1931



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Macon Registration District No. 529 File No. \_\_\_\_\_  
 Township Chariton Primary Registration District No. 5703 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mary Walker  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1855</u>		
7. AGE <u>75</u>	YEARS	MONTHS
		DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Housewife</u> (duration) _____ yrs. _____ mos. _____ ds.		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>England</u>		
PARENTS	10. NAME OF FATHER <u>James Bailey</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>England</u>	
	12. MAIDEN NAME OF MOTHER <u>Bay Crockett</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>England</u>		
14. INFORMANT <u>Joseph Walker</u> (Address) <u>Q-2. Bevier mo</u>		
15. FILED <u>4-9 1931</u> <u>J. L. Trippier</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1931

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
Jan 13 1931 to \_\_\_\_\_  
 that I last saw him alive on \_\_\_\_\_  
Jan 13 1931, and that death occurred, on the date stated above, at \_\_\_\_\_  
1045 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Angioma Chronic  
Arterio Sclerosis  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 1. (Signed) A. M. Rainey, M. D.  
16, 1931 (Address) Macon mo

\*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 Antioch Cem. DATE OF BURIAL Jan 16 1931

20. UNDERTAKER Albert Skinner ADDRESS Macon

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

THE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Make every effort to check marks, lacking from the death certificate.

Name: Mary Walker

Who died at: Macon Co. on Jan. 13, 1931

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Angioma chronic  
Angina Pectoris.

Contributory: Arterio sclerosis

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

Name of physician: Dr. J. M. Raines,

Address of physician: Macon, Mo.

5-2032