

REC'D FEB 6 1939

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

2328  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318  
 (b) Township SPRINGFIELD Primary Registration District No. 209 Registered No. 64  
 (c) City SPRINGFIELD (d) Street No. 2039 W. Grant St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 14 1/2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 2039 W. Grant St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Susan Walker  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 7, 1888  
 7. AGE YEARS 50 MONTHS 10 DAYS 14 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W.P.A. Worker  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brinkline Missouri

FATHER 13. NAME Joseph Walker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER 15. MAIDEN NAME Margarette Barnett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT (NAME) (ADDRESS) Mrs. Susan Walker Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Brinkline Mo. DATE Jan 23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin G. Palmer Springfield Mo.

20. FILED Jan 23, 1939 Chas. A. George M. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21, 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 16, 1939, to Jan 20, 1939  
 I last saw him alive on Jan 20, 1939. Death is said to have occurred on the date stated above, at 1:05 P.M.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage Date of onset Jan 1939  
of J. M.  
 Other contributory causes of importance: Hemiplegia 1938  
Arteriosclerosis

Name of operation Cholecystectomy Date of Jan 1939  
 What test confirmed diagnosis Cholecystectomy Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_

(Signed) Arthur D. Knabb M. D.  
 (Address) 450 W. E. Condit St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**