

Registration District No. 608

Primary Registration District No. 5807

State File No. _____

Registrar's No. 22

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Rural Stella Mo. R#1
(c) Name of hospital or institution:
At the Home of Son Stella R#1
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME Daniel Walker 426
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept. 22nd 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 6 12 hr. min.

9. Birthplace Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ---

MOTHER FATHER
12. Name Isie Walker
13. Birthplace H. C.
(City, town, or county) (State or foreign country)
14. Maiden name Polly Hillmes
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Martin Walker
(b) Address Stella Mo R#1

17. (a) Burial (b) Date thereof April 7 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Knexedonia Cem

18. (a) Signature of funeral director Wm. Morris Payne
(b) Address Wheaton, Mo.

19. (a) 5-4-1940 (b) Ada Collins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Newton
(c) City or town Rural Stella Mo R#1
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 4th
year 1940 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from April 2, 1940, to April 4, 1940
that I last saw him alive on April 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to High Blood Pressure
Due to _____
Other conditions (Include pregnancy within 3 months of death) 82W

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____
28. Signature A. B. Anderson (M. D. or other) _____
Address Stella Mo. Date signed _____

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.

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.....
Wm. Morris Payne....., Registered Apprentice No.....
working under my personal supervision.

Signed *Wm. Morris Payne*.....
Licensed Embalmer No. *3012*.....
P. O. Address *Wheaton Md*.....

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.