

AUG 14 1940

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

24770

Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 3 Registration District No. 104
(b) Township Fulton 6 Primary Registration District No. 3008 Registered No. 173
(c) City Fulton (d) Street No. State Hospital #7 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 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

42 Ruby FRANCES WALKER
(a) Residence, No. Centralia 140 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 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 —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 18, 1899
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 4 19
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. NONE
9. Industry or business in which work was done, as saw mill, bank, etc. Home
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) CENTRALIA, MO.

FATHER 13. NAME J. W. WALKER

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

MOTHER 15. MAIDEN NAME SUSAN F. BAY

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

17. INFORMANT (ADDRESS) Hosp. Records

18. BURIAL, CREMATION, OR REMOVAL PLACE Centralia Mo. 7/19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. ...

20. FILED July 7, 1940 P. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1940
22. I HEREBY CERTIFY, That I attended deceased from June 26, 1940 to July 7, 1940
I last saw h.e.e. alive on July 7, 1940 Death is said to have occurred on the date stated above, at 4:30 a.m.
The principal cause of death and related causes of importance were as follows:

Bronchitis Pneumonia
Date of onset 7-1-40
197W
Other contributory causes of importance:
Post Encephalitic Paradoxical Syndrome

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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) George W. Ferguson, M. D.
106 (Address) 806 Hwy #1, Fulton, Mo.

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.

No Security No.

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.....

M. J. McDonald....., 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.