

DEPARTMENT OF COMMERCE **FILLED JUN 19 1941** MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF THE CENSUS **STANDARD CERTIFICATE OF DEATH**

State File No. 17693  
 Registrar's No. 5378

Registration District No. 266 Primary Registration District No. 5378

1. PLACE OF DEATH: DENT  
 (a) County DENT  
 (b) City or town RURAL - LAKE SPRING  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 5 yrs.  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County DENT  
 (c) City or town RURAL  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME WILLIAM ALFRED WALKER

3. (b) If veteran, name war NONE 3. (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 ELIZABETH WALKER 6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased JULY 23 1865  
 (Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace OSAGE CO MO  
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business RETIRED

12. Name WM M. WALKER

13. Birthplace OSAGE CO MO

14. Maiden name MARY JANE PONTIER

15. Birthplace OSAGE CO MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant Larry Walker

(b) Address Lake Springs MO

17. (a) BURIAL (b) Date thereof JUNE 9 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LIBERTY

18. (a) Signature of funeral director How Clark

(b) Address Rolla MO

19. (a) 6-8-41 (b) \_\_\_\_\_ (Registrar's signature)  
 (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6  
 year 41 hour 7:00 minute AM

21. I hereby certify that I attended the deceased from 6-6-41  
 1941 to 6-6-41 1941;  
 that I last saw him alive on 6-1-41 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death coronary occlusion

Due to \_\_\_\_\_

Due to 440

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
240

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature E. E. Frazier M.D. (M. D. or other) \_\_\_\_\_  
 Address Rolla MO Date signed 6-8-41

Duration immediate  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 5,

District File Number 6411747

Date Filed .....

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

*Wm J Licklider*  
Licensed Embalmer No. 3191

P. O. Address St James, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17698  
Registrar's No. 47

Registration District No. 266

Primary Registration District No. 0378

1. PLACE OF DEATH:

(a) County Denton  
(b) City or town Watkins  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Wm Alfred Halser  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72-1014 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address \_\_\_\_\_

19. (a) July 9 1947 (b) A. E. K. Smith M.D.

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

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? \_\_\_\_\_ (City or town) (County) (State)

(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 \_\_\_\_\_

23. Signature E. E. J. Smith (M. D. or other)

Address Rolla Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-17698