

FILED JAN 31 1942

Registration District No. 36

Primary Registration District No. 5764

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home Temp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Mississippi

(c) City or town Rural  
(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. ....

3. (a) PRINT FULL NAME Randy Lee Walker

3. (b) If veteran, name war. ✓ 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24  
year 1941 hour 4 PM minute 00 M.

21. I hereby certify that I attended the deceased from Nov 24-41  
to Dec 1, 1941  
that I last saw him alive on Dec 1, 1941  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced S U

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 9 years (Month) (Day) (Year)

7. Birth date of deceased Aug 9 1941

Immediate cause of death Pneumonia

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

8. AGE: Years Months Days If less than one day

3 22 hr. min.

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

Major findings: Of operations .....

Of autopsy .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation ✓

11. Industry or business .....

12. Name Mr Bennie Walker

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

14. Maiden name Ester Kueger

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

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? .....

23. Signature [Signature] (M. D. or other) .....

Address 1201-41 Date signed .....

16. (a) Informant Bill Pratt

(b) Address Liberator MO

17. (a) Rural (b) Date thereof 11-2-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director National Funeral Home

(b) Address Liberator MO

19. (a) (b) (c) (Registrar's signature) [Signature]

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 142-116

Date Filed 1-23-42

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. 3954

working under my personal supervision.

Signed Kenneth Jackson

Licensed Embalmer No. ....

P. O. Address Sebaston Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2907

Registration District No. 564

Primary Registration District No. 5764

Registrar's No. ....

1. PLACE OF DEATH: Mississippi  
 (a) County Rural  
 (b) City or town  
 (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)

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.....

3. (a) PRINT FULL NAME Randy L. Walker  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month December Day 9 Year 1941 Hour..... Minute..... M.  
 21. I hereby certify that I attended the deceased from.....  
 that I last saw him..... live on..... 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s.  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Aug. 9, 1941  
 (Month) (Day) (Year)  
 8. AGE: Years - Months 3 Days 13 If less than one day..... min.

Due to Pneumonia Bronchial  
(due to influenza)  
 Due to.....  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations..... 33b  
 Of autopsy.....

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)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant.....  
 (b) Address.....  
 17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
 (Burial, cremation, or removal) (Place: burial or cremation.....)  
 18. (a) Signature of funeral director.....  
 (b) Address.....  
 19. (a) 3-5-42 (b) F. A. Vernon  
 (Date received local registrar) (Registrar's signature)

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?  
 (Specify type of place)  
 While at work?..... (e) Means of injury.....  
 23. Signature Frank A. Vernon (M. D. or other).....  
 Address Charleston Mo Date signed.....

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

SUPPLEMENTARY

