

S. No. 2
M-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1942

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33004
State File No. _____
Registrar's No. 3782

Registration District No. 149

Primary Registration District No. 1002

48
3
803
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3516 Summit Street,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 months
In this community 31 years,
years, months or days

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson, 3
(c) City or town Kansas City, 8
(If outside city or town limits, write "RURAL")
(d) Street No. 3720 Bell Street,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x 0

3. (a) PRINT FULL NAME Mrs. Pearl R. Walker,
3. (b) If veteran, name war No.
3. (c) Social Security No. No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 13th,
year 1942 hour 4:55 minute A. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife James S. Walker,
6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased July 26 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April - 25
1936, to Oct 12 1942
that I last saw h. er alive on Oct 12 1942
and that death occurred on the date and hour stated above.

8. AGE: Years 64-65 Months 24 Days 18
If less than one day
hr. min.

Immediate cause of death Brain abscess Duration 4 month
left middle lobe
Due to Chronic mastoiditis 50 years

9. Birthplace Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Teacher,

Due to 89 B
Other conditions (include pregnancy within 3 months of death)
Major findings: Chronic mastoiditis
Brain abscess
Of autopsy

11. Industry or business School,
12. Name George W. Roberts,
13. Birthplace Missouri,
(City, town, or county) (State or foreign country)
14. Maiden name Nannie Littlejohn,
15. Birthplace Missouri,
(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?
While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant Mrs. J. J. Long,
(b) Address Lexington, Missouri,
17. (a) Form Burial, (b) Date thereof 10-15-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery
18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C. Mo.
19. (a) 10-13-42 (b) M. M. Cronin
(Data received local registrar) (Registrar's signature)

23. Signature Sam E. Roberts (M. D. or other) J
Address Prof. Bry. KCMU Date signed 10/13/42

Dr. Sam E. Roberts,

Proprietor / R.M.

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.....

E. M. Plank

Licensed Embalmer No.....

1848

P. O. Address.....

W. C. 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.