

S. No. 2
M-8-43
v. 5-17-39
X37823

FILED NOV 6 7

Registration District No. **67**

Primary Registration District No. **4118**

Registrar's No. **90**

1. PLACE OF DEATH:

(a) County **Christian**

(b) City or town **Sparta Mo.**
(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 _____ years, months or days) **2 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Christian**

(c) City or town **Sparta Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Robert D. Walker.**

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** **Married**

6. (b) Name of husband or wife **Mary Walker** **(c) Age of husband or wife if alive** **50** years

7. Birth date of deceased **Feb 3 1876**
(Month) (Day) (Year)

8. AGE: Years **69** Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation **oil Co. employ**

11. Industry or business

12. Name **Archer B. Walker**

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

14. Maiden name **Elizabeth Walker**

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

16. (a) Informant **L. A. Walker**

(b) Address **Seminole Okla.**

17. (a) Burial **(b) Date thereof** **Oct 17 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rixley**

18. (a) Signature of funeral director **T. R. Chaffin**

(b) Address **Sparta Mo.**

19. (a) Oct 17 45 **(b) Willie Barr**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct**, day **13**th
year **1945** hour **5** minute **10** M.

21. I hereby certify that I attended the deceased from **Aug 1944** to **Oct 13 1945**
that I last saw him alive on **Oct 10 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Valvular Heart Disease**

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy **928**

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 **J. H. Hade** (M. D. or other)

Address **Sparks Mo.** **Date signed** **10-15-45**

Duration _____

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. 6,
District File Number 1143-1061

Date Filed NOV 5 1945

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.