

FILED APR 24 1946
Registration District No. 144

Primary Registration District No. 5562

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Iron
 (b) City or town Quadia Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: The Home Land Baptists 5
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 yr. 1 mo. 2 days
(Specify whether)
 In this community 1 yr. 1 mo. 2 days
(years, months or days)

3. (a) PRINT FULL NAME Lydia Missouri Walker
3. (b) If veteran, name war: ✓
3. (c) Social Security No. none

4. Sex Female **5. Color or race** white
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William Walker
6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased. Aug. 13, 1863
(Month) (Day) (Year)

8. AGE:
 Years 82 Months 8 Days 6
 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business her home

MOTHER FATHER
12. Name Frederick Miller
13. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)
14. Maiden name Annette Bligh
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. H. B. Buisson
(b) Address Brantown, Mo.

17. (a) REMOVAL (Burial, cremation, or removal) **(b) Date thereof.** 4-20-46
(Month) (Day) (Year)

(c) Place: burial or cremation Old City Cemetery

18. (a) Signature of funeral director Stanley Sumner

(b) Address JEFFERSON CITY - MISSOURI

19. (a) 5-4-46 **(b)** Mrs. Ann Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Iron 47
 (c) City or town Quadia-Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 1 1/2 Miles East on Highway 70
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
 year 1946 hour 3 minutes 35 P.M.

21. I hereby certify that I attended the deceased from April 12
1946 to April 1946
 that I last saw her alive on April 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death acute Bronchial pneumonia
4/15/46

Due to acute nose-plunging
4/1/46

Due to Chronic arthritis

Other conditions Chronic arthritis
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy 1150

Duration

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 6

23. Signature R. E. Harland (M. D. or other)
 Address Brantown, Mo. Date signed 4/19/46

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APR 24 1946

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. 4/19/46
working under my personal supervision.

Signed Geo. P. Lendel

Licensed Embalmer No. 3475

P. O. Address Quincy, 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.

Registration District No. 144

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1. PLACE OF DEATH:
(a) County Iron
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days
3. (a) PRINT FULL NAME Lydia M. Walker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ years (Day) (Year)
7. Birth date of deceased aug 13 (Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ (If less than one day, hr. min.)
9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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) (Place: burial or cremation)
13. (a) Signature of funeral director _____ (b) Address _____

19. (a) 5-4-46 (b) Mrs Aris Jones
(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 _____ 1946
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her _____ 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)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

13004