

3. No. 2
12-45
5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9469**
1438
Registrar's No. _____

FILED APR 8 1947
Registration District No. **199**

Primary Registration District No. **6002**

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:
1711 Myrtle
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none
(Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 1711 Myrtle **8**
(If rural, give location)

(e) Citizen of foreign country? no **0**
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William S. WALKER

3. (b) If veteran, name war WORLD WARS I&II

3. (c) Social Security No. 486-05-1173

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 26
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex male **C**

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lydia Walker

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased October 28, 1896
(Month) (Day) (Year)

that I last saw h_____ alive _____, 19____, and that death occurred on _____ date and hour stated above.

Immediate cause of death Reputy Coronar Acute Coronary Occlusion

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>4</u>	<u>27</u>	<u>28</u> hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation Electrician

Major findings _____

11. Industry or business Todd Electric Co.

Of operations _____

12. Name Samuel Allen Walker

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

14. Maiden name Rose Ella Ramsey

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

16. (a) Informant Mrs. Lydia Walker

(b) Address 1711 Myrtle, K. C., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Melody-McGilley-Evlar

(b) Address Kansas City, Missouri

19. (a) 3-27-47 (Date received local Registrar) (b) Geraldine Holmes (Registrar's signature)

Of autopsy See Above

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)

23. Signature A. E. Walker M.D. (M. D. or other title)
2800 Main St. 3/25/47

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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

APR 18 1947

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.....

Licensed Embalmer No.: 2999

P. O. Address..... KC

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. 149Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas city
(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 William S. Walker

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-27-47 (b) Stheraldine Holmes (c) _____ (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 March Day 25
Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw him _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute coronary occlusion

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 94A

Major findings: _____

Of operations _____

Of autopsy see above

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 A. E. Upsher (M. D. or other) _____Address 2800 Main Date signed 3-26-47

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

MOTHER FATHER

SUPPLEMENTAL

9469