

FILED JAN 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 991

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene 39	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	c. LENGTH OF STAY (in this place) 20 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 6	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 840 West Elm /		d. STREET ADDRESS (If rural, give location) 840 West Elm 0	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Walter	b. (Middle) E	c. (Last) Walker	— (Month) — (Day) — (Year)	January	18 1949

5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Jan 22, 1879	9. AGE (In years last birthday) 69	10. IF UNDER 1 YEAR Months	11. IF UNDER 1 YEAR Days	12. IF UNDER 1 MIN. Hours	13. IF UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME John Walker	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sarah A Walker (West)	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-05-0846	17. INFORMANT'S SIGNATURE OR NAME Sarah A Walker, 840 W Elm, Springfield		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>High Blood Pressure</u>					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>				
	DUE TO (c) <u>Arteriosclerosis & emphysema last few days</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4500			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 0
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22. I hereby certify that I attended the deceased from Apr 27, 1948, to Jan 18, 1949, that I last saw the deceased alive on Jan 17, 1949, and that death occurred at 2:28 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>E. R. Evans</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>515 1/2 Dallery, Springfield Mo</u>	23c. DATE SIGNED <u>Jan 15/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 20, 1949	24c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri ✓
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DATE REC'D BY LOCAL REG. 1-20-49	REGISTRAR'S SIGNATURE <u>W. E. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer Funeral Home</u>	ADDRESS <u>Springfield Missouri</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed

Jewell E. Kirdle

Licensed Embalmer No. *2831*

P. O. Address *Springfield*

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.