

FILED MAR 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5363

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 5704 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheeling</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheeling</u>	
c. LENGTH OF STAY (In this place) <u>7 years</u>		d. STREET ADDRESS (If rural, give location) <u>Wheeling</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wheeling, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Andrew</u> c. (Last) <u>Walkup</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-26-50</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White(US)</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-26-1894</u>
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mts. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Pharmacist</u>	11. BIRTHPLACE (State or foreign country) <u>Eversonville, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Andrew F. Walkup</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy H. Lowery</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie J. Smith Walkup</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John L. Walkup, Wheeling, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  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	
19c. INTERVAL BETWEEN ONSET AND DEATH		19d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1948</u> , to <u>Feb 25, 1950</u> , that I last saw the deceased alive on <u>Feb 25, 1950</u> , and that death occurred at <u>4:10 a.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M. Brown, M.D.</u>		23b. ADDRESS <u>Wheeling, Mo.</u>	
23c. DATE SIGNED <u>2-28-50</u>		23d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-28-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling</u>		24d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Feb-28-50</u>		REGISTRAR'S SIGNATURE <u>Frances R. Newell</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funeral Home</u>		ADDRESS <u>Chillicothe, Mo.</u>	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

MAR 28 1950



**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.

Student .....  
Student Embalmer

Signed *Joseph M. Gibson*  
Licensed Embalmer No. *4769*

P. O. Address *Chillicothe, 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.