THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30572
STATE FILE NUMBER

FILED SEP 4 1957

Registration District No. 338 Primary Registration District No. 6148 Registrar's No. 30

1. PLACE OF DEATH
a. COUNTY Stoddard
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bell City; Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence Length of stay in Ib 13 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Stoddard
c. CITY OR TOWN Bell City, Inside Limits Yes ☐ No ☒
d. STREET ADDRESS Rural (If outside, give location) Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Ed, Middle: xxxxx Last: Walker
4. DATE OF DEATH Month: 8, Day: 27, Year: 1957
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH December 15, 1890
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months 8 Days 11 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) xxxx Comen
10b. KIND OF BUSINESS OR INDUSTRY Labor
11. BIRTHPLACE (City and state or country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
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. 723,05,1350
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchial Asthma — 2 years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of Liver
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY. Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 5-2-55, to 8-22-57 and last saw him alive on 8-22-57
Death occurred at 7:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE James O. Carson (Degree or title) D.O.
22b. ADDRESS Bloomfield - Mo
22c. DATE SIGNED 8-28-57
23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 9-1-57
23c. NAME OF CEMETERY OR CREMATORY Carpenter
23d. LOCATION (City, town, or county) N.W. Sikeston (State) Mo.
24. FUNERAL DIRECTOR Fred J. Smith ADDRESS 1212 Maud
25. DATE RECD. BY LOCAL REG. 8-29-57
26. REGISTRAR'S SIGNATURE Mrs. George L. Baker

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related.

SEP 6 1957

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Fred J. Smith

Licensed Embalmer No. 4.

P. O. Address Sitka

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.