

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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FILED VS NOV 1 0 1960

**-60-038987**

ENDED

Registration District No. 200 Primary Registration District No. \_\_\_\_\_ Registrar's No. 170

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Macon</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sue City Johnston</u>		Length of stay in 1b <u>40 yr</u>	c. CITY OR TOWN <u>Sue City LA PLATA.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RURAL ROUTE.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jessie</u> Middle <u>Agnes</u> Last <u>Walker</u>			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>26</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>25 May 1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edina, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Harry Tonkinson</u>		13b. MOTHER'S MAIDEN NAME <u>Martina Woodward</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel E. Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>486-44-0356</u>	17. INFORMANT Address <u>LA PLATA</u> <u>Samuel E. Walker</u> <u>Sue City, Mo</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Oct 4 1960</u> to <u>Oct 26 1960</u> and last saw her alive on <u>Oct 26 1960</u> Death occurred at <u>10:45 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>O. L. Woodward Do</u>			22b. ADDRESS <u>Atlanta Ga</u>		22c. DATE SIGNED <u>10-28-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>28 Oct '60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Locust Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Knox County, Mo</u>	
24. FUNERAL DIRECTOR <u>HUDSON-RIMER FUNERAL HOME</u>		ADDRESS <u>Edina, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10/31/60</u>	26. REGISTRAR'S SIGNATURE <u>Patricia DeGrady</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed ABR

Licensed Embalmer No. 504

P. O. Address China, T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.