

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Buchanan
Township
or
Village
or
City St. Joseph (No. 407 South 15th St. Ward)

Registration District No. 85 File No. 3820
Primary Registration District No. 1001 Registered No. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Wesley Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 24, 1826
(Month) (Day) (Year)

7 AGE 88 yrs. 10 mos. 7 ds. IF LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed (or employer) Contractor & Builder

9 BIRTHPLACE Philomont Loudoun Co Va
(City or town, State or foreign country)

PARENTS
10 NAME OF FATHER Benjamin Walker
11 BIRTHPLACE OF FATHER Loudoun Co. Va
(City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Elizabeth Kyle
13 BIRTHPLACE OF MOTHER Penn.
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. H. Ross
St. Joseph Mo.
(Address)

15 Filed Feb 2 1915 W. H. Harrington
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 1st, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov. 14, 1914 to Jan 31, 1915, that I last saw him alive on Jan 31, 1915, and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:
Smile & angrene of Foot

Arterio Sclerosis
(Duration) 2 yrs. 20 ds.

CONTRIBUTORY Arterio Sclerosis
(Secondary) unknown
(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) W. A. Astor M. D.
Feb 2, 1915 (Address) St. Joseph Mo.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 48 yrs. 3 mos. 0 ds. In the State 53 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL St. Mary Cemetery
DATE OF BURIAL Feb 3rd, 1915
ADDRESS St. Joseph Mo.

By W. H. Harrington
Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Buchanan

Township _____

or Village St. Joseph

City St. Joseph (NO. _____)

Registration District No. 85

File No. _____

Primary Registration District No. 1001

Registered No. 114

St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wesley Walker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M
(Write the word)

DATE OF DEATH Feb. 1, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ mins.

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS NAME OF FATHER _____ BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

(Duration) _____ yrs. _____ mos. _____ ds. Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) H. H. Prestover M. D. Feb. 2, 1915 (Address) Logan, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

Filed Mar 29 1915 W. E. Harrington REGISTRAR

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY Satisfactory Information Supplied

Physicians should state in full, in form, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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[Approved by U. S. Census and American Public Health
Association]

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