10332

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

1 PLACE OF DEATH

County Jasper

Township or Village or City Webb City (NO. E. Church St.; Ward)

Registration District No. 417 File No. 10056

Primary Registration District No. 301 Registered No. 74

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

2 FULL NAME Mildred E. Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Child

6 DATE OF BIRTH May (Month) 22 (Day), 1906 (Year)

7 AGE 12 yrs. 10 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Detroit Mich.

PARENTS

10 NAME OF FATHER O. F. Walker

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa

12 MAIDEN NAME OF MOTHER Nellie Brock

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. F. Walker

(Address) Webb City Mo.

15 Filed 3/30, 1919 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 28 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 3-1, 1919, to 3-28, 1919, that I last saw her alive on 3-27, 1919, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

~~Bro~~ Bronchopneumonia

11A

107A

10

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Kelly M. D.

3-30, 1919 (Address) Webb City, Mo.

*State the Disease Causing Death, or, in deaths 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 ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Hope Cem

DATE OF BURIAL 3/30, 1919

20 UNDERTAKER Webb City Hand Co

ADDRESS Webb City

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death o
hospital or
give its NA
of street and

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 19
(Month) (Day)

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to ....., 1

that I last saw h.....alive on ....., 1

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....

(Signed) .....

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra
or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER	ADDRESS