

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

Walker

36056

1. PLACE OF DEATH

County Henry
 Township Clinton
 City Clinton

Registration District No. 350-353
 Primary Registration District No. 3018

File No. 144
 Registered No. 144
 St. 2nd Ward

2. FULL NAME

(a) Residence No. 310 S. Water St. 2nd Ward.
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kathryn Efferth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15, 1876

7. AGE YEARS 47 MONTHS 5 DAYS 36 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Fort Scott
 (STATE OR COUNTRY) Kansas

10. NAME OF FATHER Jacob H. Efferth

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Know
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah A. Horn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont Know
 (STATE OR COUNTRY)

14. INFORMANT Kathryn Efferth
 (Address) Clinton Mo

15. FILED 12/22/23 E. O. Peeler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11, 1923

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1923, to Dec 11, 1923, that I last saw alive on Dec 11, 1923, and that death occurred, on the date stated above, at 4 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Taken Pneumonia
110
100

CONTRIBUTORY (SECONDARY) Influenza

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

(DID AN OPERATION PRECEDE DEATH? no DATE OF Dec 11, 1923)

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. O. Walker, S., M. D.

Dec 11, 1923 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield, Mo DATE OF BURIAL 12/15, 1923

20. UNDERTAKER Simms-Wilkinson ADDRESS Clinton

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

R. 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.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No.)..... St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If less than 1 day, hrs. min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY..... (duration)..... yrs. mos. da. (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. da.

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

*State the DISEASE CAUSING DEATH, or in deaths from Violent Causes, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS..... 19.....