SEP 29 1927

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

Do not use this space.

24924

1. PLACE OF DEATH
County Miss
Township Wolf Island
City
Registration District No. 567
Primary Registration District No. 5767
File No.
Registered No. 43
(No. , St. Ward)

2. FULL NAME Thomas Walker
(a) Residence. No. Wolf Island St., 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 10th 1908

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
18	5	9	

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

9. BIRTHPLACE (CITY OR TOWN) Wolf Island Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Bill Walker
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Wolf Island Mo
12. MAIDEN NAME OF MOTHER Callie Turner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Wolf Island Mo

14. INFORMANT Milis Lee
(Address) Charleston Mo

15. FILED 8-25 19 Duff M. Hodges
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19th 1927

17. Inquest
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 2 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Killed with pistol shot from the hands of Mable Burnett Murdered
173 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 197
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Inquest
(Signed) Milis T Lee Justice of Peace M.D.
8-20, 1927 (Address) Charleston Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wolf Island
DATE OF BURIAL 8-20- 1927

20. UNDERTAKER Private
ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miss — Registration District No. 567 — File No. .....

Township Wolf Island — Primary Registration District No. 5767 — Registered No. 43

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Walker

(a) Residence. No. ..... St., ... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 10 - 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	19	5	9	

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)

PARENTS

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 8-25, 1927 Duff M Hodges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

, 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS Wolf Island Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES U...