

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

Do not use this space.

13991

1928

1. PLACE OF DEATH
 County Macon Registration District No. 527
 Township _____ Primary Registration District No. 4313
 City Bevier (No. _____) St. _____ Ward _____

2. FULL NAME Lafayette B. Walker
 (a) Residence. No. _____ St. _____ Ward Brookfield
 (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. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-5-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 4 19 — — —

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work P. P. Conductor
 (b) General nature of industry, business, or establishment in which employed (or employer) C. B. & O.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New Columbia
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER T. H. Walker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Do Not Know
 (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER _____

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

PARENTS

14. INFORMANT Mrs. Anna Walker
 (Address) Brookfield Mo.

15. FILED 4/24, 28 Ted Peace
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Mar. 31, 1928, to Apr. 24, 1928 that I last saw him alive on Apr. 24, 1928, and that death occurred, on the date stated above, at 1:30 P. M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ischaemic Pneumonia (right lung)
 (duration) _____ yrs. _____ mos. 25 da.
 CONTRIBUTOR (Endocarditis, malignant)
 (SECONDARY) Hemiplegia (duration) _____ yrs. _____ mos. 14 da.

18. WHERE WAS DISEASE CONTRACTED 10th
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Dr. L. W. Judlich
Apr. 24, 1928 (Address) Bevier, 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 Post Hill DATE OF BURIAL 4-26-28

20. UNDERTAKER C. White ADDRESS Brookfield

N. B. Every item of information should be carefully supplied. AGE known or supposed. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PHYSICIAN
PATIENT

AGE of child
SEX
ADDRESS

DEATH
DATE

Report

**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 Macon Registration District No. 527 File No.
 Township Primary Registration District No. 4213 Registered No. 11
 City Bevier (No.) St. Ward)

2. FULL NAME Lafayette B. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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. or 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 Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't know

14. INFORMANT

(Address)

15. FILED 4/24/28 Ted Peake

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 24 1928

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 (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

20. UNDERTAKER

ADDRESS

19

N. I. S. B. H. should be carefully supplied. A statement of OCCUPATION is very important.

REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-13991