AUG 30 1928

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

Do not use this space.

1. PLACE OF DEATH
County Wright — Registration District No. 911 — File No. 26287
Township Montgomery — Primary Registration District No. 6227 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME .....
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: Female
4. COLOR OR RACE: white
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) 7-15 1928

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
0	0	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Eldrage E. Walker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Manes
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ada A Wade
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Manes
(STATE OR COUNTRY) Mo

14. INFORMANT E. E. Walker
(Address) Manes Mo

15. FILED 7-20 1928 B. L. Johnston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-16 1928

17. I HEREBY CERTIFY, That I attended deceased from 7-15, 1928, to 7-16, 1928 that I last saw her alive on 7-16, 1928, and that death occurred, on the date stated above, at 5-30-P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
5½ month baby to young to live
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 16 [illegible]
(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) B. L. Johnston, M. D
, 19 (Address) Manes 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: Manes Cemetry — DATE OF BURIAL: 7-17 1928

20. UNDERTAKER: Broyles & Wade — ADDRESS: Manes Mo

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD