

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

Do not use this space.

6808

97A

1. PLACE OF DEATH

County W. 6001
Township W. 1
City W. C. Mo.

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 4603-E-130 St. 14 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Child</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan. 17-1929</u>					
7. AGE		YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>	<u>10</u>	<u>10</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Child</u> (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) <u>W. C.</u>					
PARENTS	10. NAME OF FATHER <u>Lee Walker</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>				
	12. MAIDEN NAME OF MOTHER <u>Luis Brown</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>W. C.</u>				
14. INFORMANT (Address) <u>Lee Walker</u> <u>4603-E-130</u>					
15. FILED <u>7/27</u> , 19 <u>29</u> <u>M. M. Connor</u> REGISTRAR <u>W. C.</u>					

MEDICAL CERTIFICATE OF DEATH

1. 1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 1929, to _____, 1929, and that I last saw him alive on Feb. 24 1929, and that death occurred, on the date stated above, at _____, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
(Primary)

107A (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) 1000 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH. no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical diagnosis
(Signed) Henry George, M. D.
7/27, 1929 (Address) 2618 Elmwood

*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 <u>Elmwood</u>	DATE OF BURIAL <u>Feb 27 1929</u>
20. UNDERTAKER <u>Rose Anderson</u>	ADDRESS <u>City</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Dr. George
Cleveland