

APR 23 1930

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

Do not use this space.

7875

1. PLACE OF DEATH

County Butter
Township Poplar Bluff
City Poplar Bluff (No.)

Registration District No. 89
Primary Registration District No. 3087

File No.
Registered No. 43
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward. Bloomfield MO
(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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 4 20

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Thos B. Walker

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Eva B. Walker
(Address) Poplar Bluff

15. FILED 13/3 19 30 Dr J. C. ... REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1 19 30

17. I HEREBY CERTIFY, That I attended deceased from 2-1- 1930 to 3-1 1930
that I last saw him alive on 3-1 1930 and that death occurred, on the date stated above, at 5:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary
arteriosclerosis
4 1/2 (duration) yrs. 4 mos. ds.
CONTRIBUTORY (SECONDARY) 4 1/2 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-2-30

WAS THERE AN AUTOPSY? Yes

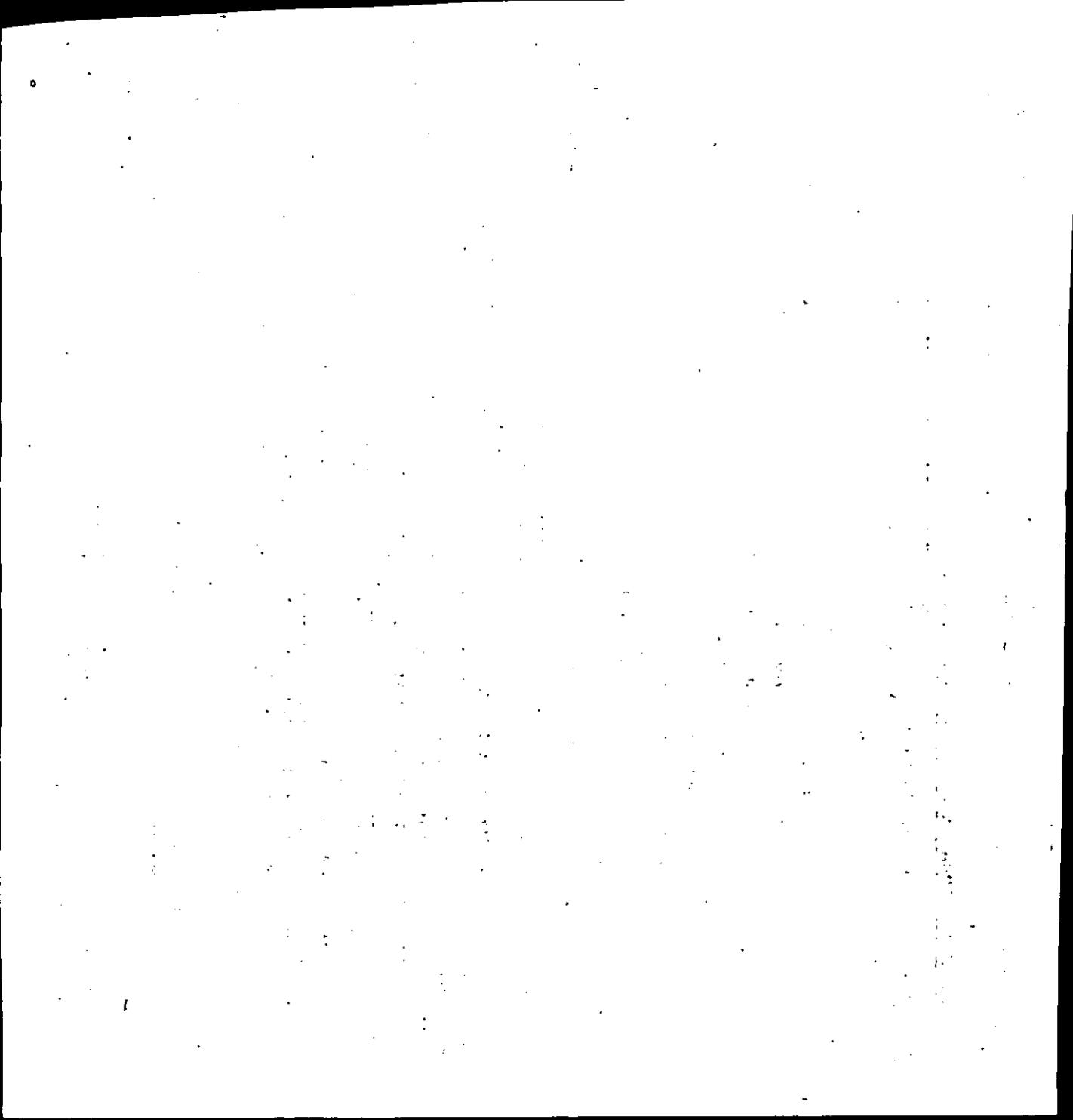
WHAT TEST CONFIRMED DIAGNOSIS Dr. ...

(Signed) J. W. ..., M. D.
Dr. ... (Address) Poplar Bluff

*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 Antioch DATE OF BURIAL 3-2 19 30

20. UNDERTAKER Frankland C. Poplar Bluff ADDRESS



**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 Butler Registration District No. 89 File No.
 Township Doplar Bluff Primary Registration District No. 3007 Registered No. 43
 City (No.) St. Ward)

2. FULL NAME

Jan W. 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 Stenkowitz

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

14. INFORMANT (Address)

15. FILED 3/8-30 Dr B J Clue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/1 19 30

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw him alone 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 19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-7875-