Dr Wright
Wilson Co. Mo

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

Do not use this space.

10617

File No. 2521
Registered No.

1. PLACE OF DEATH

County
Registration District No. 791
Township
Primary Registration District No. 1003
City St Louis (No. Mo Baptist Hosp St. Ward)

2. FULL NAME Richard Asbury (Walker) Walker

(a) Residence. No. 4024 Lindell St., 19 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 11 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	54	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician
(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) Texas

PARENTS
10. NAME OF FATHER Thos F Walker
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ill
12. MAIDEN NAME OF MOTHER Alice Ann Peters
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT Mrs R. Walker
(Address) 4024 Lindell

15. FILED 19 Mary C Harvey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch 13 1930

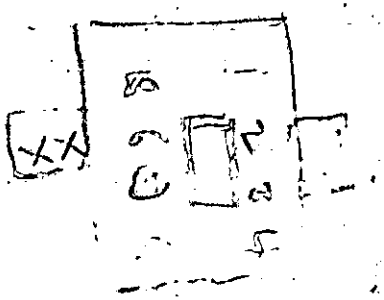
17. I HEREBY CERTIFY, That I attended deceased from Mch 9, 1930, to Mch 12, 1930 that I last saw him alive on Mch 12, 1930, and that death occurred, on the date stated above, at 7.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Operation for cancer ascending colon and
46C
(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) Condition preceding operation
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Mch 10/30
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Pathologic Exm Specimen
(Signed) A. R. Kieffer, M. D.
Mch 13, 1930 (Address) 4480 Westminster

*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
Valhalla	3/15 1930
20. UNDERTAKER	**ADDRESS**
A Ellis	5740 Delmar

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.