

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

Do not use this space.

18671

1. PLACE OF DEATH **85**
 County Buchanan Registration District No. _____
 Township _____ Primary Registration District No. **1001**
 City St. Joseph (No. **306 So. 19th St.**)

File No. _____
 Registered No. **690**
 St. _____ Ward)

2. FULL NAME India Walker
 (a) Residence. No. 306 So. 19th St. 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 Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam Walker
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 8th 1863
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 5 8

8. OCCUPATION OF DECEASED Housewife
 (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) Clinton Co. Mo.
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER Mat. Speirs
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown
 12. MAIDEN NAME OF MOTHER Hattie Carpenter
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY) Mo.

14. INFORMANT Dasie Hays
 (Address) 306 So. 19th St.

15. FILED JUN 18 1930 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JUNE 16 1930
 17. I HEREBY CERTIFY, That I attended deceased from 9th June, 1930, to 16th June 1930 that I last saw her alive on 16th June, 1930 and that death occurred, on the date stated above, at 6:10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage, Apoplexy

CONTRIBUTORY (SECONDARY) 744M
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) [Signature], M. D.

17th June 1930 (Address) St. Joseph, 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 Lathrop Mo. DATE OF BURIAL 6/18/30

20. UNDERTAKER Ramsey Funeral Service ADDRESS 9th & Olive

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.

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