

NOV 28 1930

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

Do not use this space.

35113

1. PLACE OF DEATH

County St. Louis  
Township North  
City North (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward)

Registration District No. 838  
Primary Registration District No. 4509

File No. \_\_\_\_\_  
Registered No. 47

2. FULL NAME Daniel W. Walker

(a) Residence. No. 15 E. McCullum St. North Ward. \_\_\_\_\_  
(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 - 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

17. I, HEREBY CERTIFY, That I attended deceased from Oct 18, 1930, to Oct 21, 1930 that I last saw him alive on Oct 21, 1930, and that death occurred, on the date stated above, at 2:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 8 - 1848

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
86 11 13

Edema of lung  
Fracture surgical neck of Right Femur (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

CONTRIBUTORY (SECONDARY) Fracture surgical neck of Right Femur (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)

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

10. NAME OF FATHER Don't know

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

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

WAS THERE AN AUTOPSY? No.

12. MAIDEN NAME OF MOTHER Don't know

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) Stanley S. Davis, M. D.

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

. 19 (Address) North

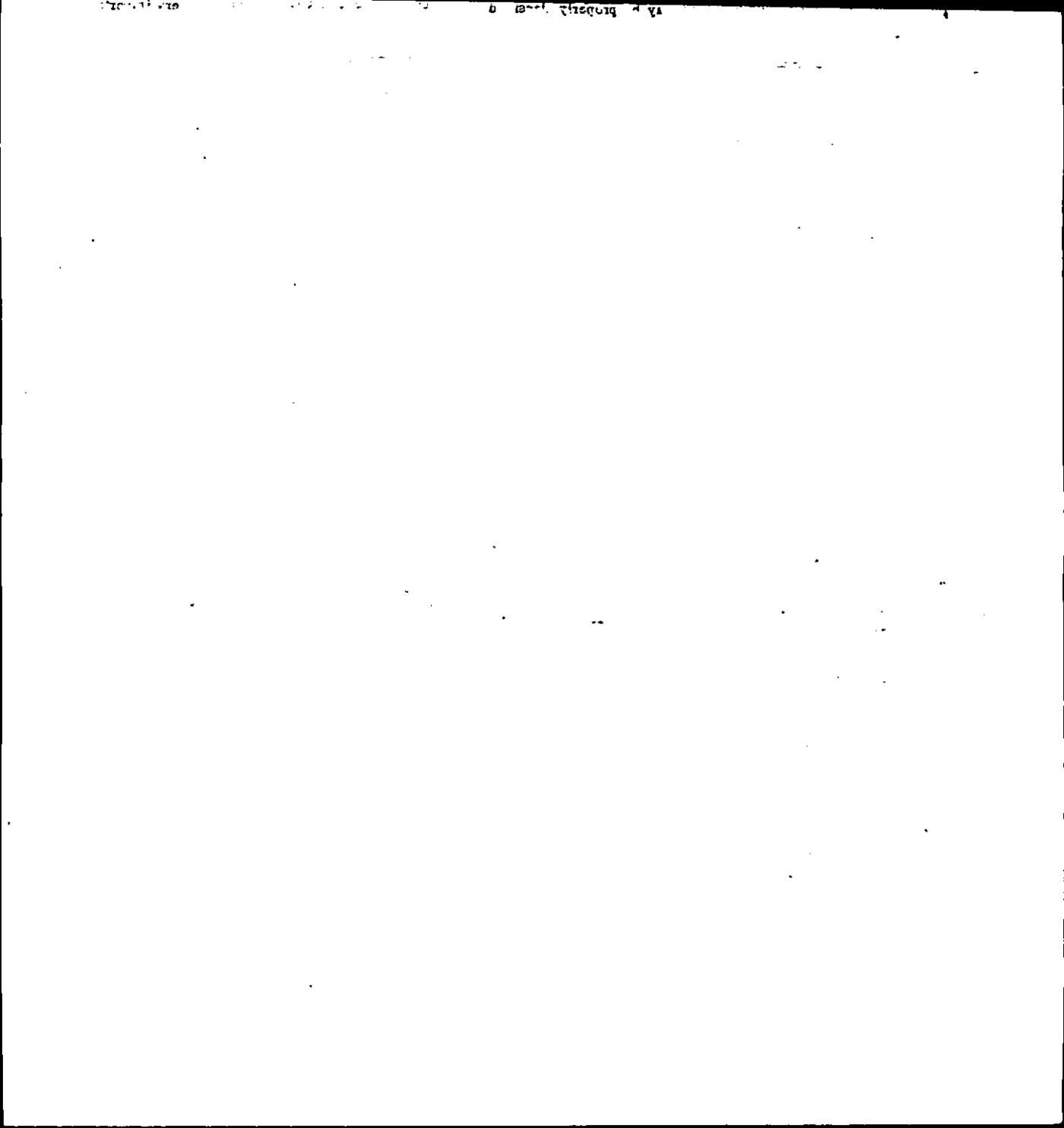
14. INFORMANT William R. Magee  
(Address) North

\*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.

15. FILED 10/21, 1930 F. Labrie REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL N. Antioch DATE OF BURIAL 10/22 1930

20. UNDERTAKER C. O. Bigg ADDRESS North



**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 Stoddard Registration District No. 838 File No. ....  
 Township Dexter Primary Registration District No. 4579 Registered No. ....  
 City Dexter (No. ....) St. .... Ward)

**2. FULL NAME**

Daniel 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

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

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

14. INFORMANT (Address)

15. FILED 19... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 19 30

17. I HEREBY CERTIFY That I attended deceased from 19... 19... that I last saw him alive on 19... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Elective of lungs  
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Fracture Surgical neck of rt. femur  
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED (Fall off back porch)  
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? 187

(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 BE CHARGED WITH FEE FOR CERTIFICATES UNTIL THEY ARE PRESCRIBED BY LAW  
 CAUSE OF DEATH TO BE WRITTEN IN FULL, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact (inform) of OCCUPATION is very important.

**SUPPLEMENTARY**

5-35113