

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

Do not use this space.

5745

888

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township East Primary Registration District No. 1002  
City Chauvin City (No. General Hosp # 2) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

**2. FULL NAME**

(a) Residence. No. 1502 E. 16<sup>th</sup> St. Ward. 2  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 34 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1883

7. AGE YEARS 48 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer) 235  
(c) Name of employer \_\_\_\_\_

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

PARENTS

10. NAME OF FATHER Lowell Walker

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

12. MAIDEN NAME OF MOTHER Harriet Taylor

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

14. INFORMANT Anna Hall  
(Address) 1716 N. Roland

15. FILED 2-21-31 m m Crowe  
REGISTRAR ant

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 19 1931

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_  
Feb. 18, 1931, to \_\_\_\_\_  
Feb. 19, 1931  
that I last saw him alive on \_\_\_\_\_  
Feb. 9, 1931, and that death occurred, on the date stated above, at \_\_\_\_\_  
3:25 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral Apoplexy  
87A

CONTRIBUTORY (SECONDARY) GA  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
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) W. M. Miller M. D.

(Address) Gen. Hospital no 2  
\*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 Hoodlawn Cem. Insp. DATE OF BURIAL 2/22 1931

20. UNDERTAKER Hatkins Bros. Und. Co. 1729 Lydia  
ADDRESS \_\_\_\_\_

WRITE IN INK WITH OUTFACING 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.

