

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.

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

Do not use this space.

OCT 11 1934

32149

1. PLACE OF DEATH

15 County Camden
Township Warren
City (No. _____) _____

Registration District No. 121
Primary Registration District No. 5-173

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Harison Walters

(a) Residence, No. _____ St. _____ 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) <u>Evaline Walters</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 23-1878</u>				
7. AGE	YEARS <u>56</u>	MONTHS	DAYS <u>1</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MO</u>				
FATHER	13. NAME <u>David Walters</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>			
MOTHER	15. MAIDEN NAME <u>Don't know</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>			
17. INFORMANT (ADDRESS) <u>Wilber Walters Decaturville</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>MT Habor Cemetery</u> DATE <u>9-25-1934</u>				
19. UNDERTAKER (ADDRESS) <u>none</u>				
20. FILED <u>10-8</u> 19 <u>34</u> <u>Becca Claiborn</u> Registrar.				

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-24, 1934

22. I HEREBY CERTIFY, That I attended deceased from 9-20, 1934 to 9-24, 1934
I last saw him alive on 9-24, 1934 Death is said to have occurred on the date stated above, at 9A m.
The principal cause of death and related causes of importance were as follows:
Chronic Nephritis Date of onset 32
131
131

Other contributory causes of importance:
none

Name of operation none Date of _____
What test confirmed diagnosis? Phys Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) E. O. Laubach, M. D.
(Address) Decaturville

