Duplicate

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

Do not use this space.

NOV 13 1934

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Barnes Hosp St. ..... Ward)

File No. 37913

Registered No. 14400

2. FULL NAME Thomas Perkins Walker

(a) Residence, No. ..... St., MR Ward. Patoka Ill
(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 ~~F~~ M

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Elizabeth

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 28, 1866

7. AGE ~~68~~ YEARS 67 MONTHS 7 DAYS 18 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. farmer

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) Virginia

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rastus Walker Virginia

MOTHER

15. MAIDEN NAME Nancy Bruenfield

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Leo Walker Patoka Ill

18. BURIAL, CREMATION, OR REMOVAL Hillcrest Cem, Patoka, Ill DATE Oct 17 1934

19. UNDERTAKER (ADDRESS) Linton Beery Patoka, Ill

20. FILED OCT 27 1934 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16-1934

22. I HEREBY CERTIFY, That I attended deceased from 10-16, 1934, to 10-16, 1934

I last saw him alive on 10-16, 1934. Death is said to have occurred on the date stated above, at 12:45 pm.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis Streptococcic	
Carcinoma of Nose	
Broncho pneumonia	

Other contributory causes of importance:

57

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... 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? .....

If so, specify .....

(Signed) C. L. Linton, M. D.

(Address) 4621 Park View

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.

WHITE PAPER WITH ORANGE INK—THIS IS A PERMANENT RECORD

SUPPLEMENTARY

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

Do not use this space.
37913
10400

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. ~~[illegible]~~

Township ..... Primary Registration District No. 1003 Registered No. .....

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Thomas Perkins 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

DATE OF BIRTH (MONTH, DAY, AND YEAR)

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

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 .....

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

13. NAME

14. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

INFORMANT .....
(ADDRESS)

BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19....

UNDERTAKER .....
(ADDRESS)

FILED 10-27 1934 Jos. J. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-16 1934

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
5-7	
Non-epidemic encephalitis	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

WRITE PLAINLY, WITH UNFADING 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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

Do not use this space.

37913

File No. .....

Registered No. 6553

1. PLACE OF DEATH

County.....

Township.....

City..... (No..... , ... St. ..... Wa

Registration District No.....

Primary Registration District No.....

2. FULL NAME.....

(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. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*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.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

17. INFORMANT.....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE.....19.....

19. UNDERTAKER.....
(ADDRESS)

20. FILED..... (..... 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased
....., 19....., to.....,

I last saw h..... alive on....., 19..... Death l

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as fol

Date o

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify.....

(Signed)..... , M

(Address).....