

JUL 14 1936

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

Do not use this space.

21547

1. PLACE OF DEATH

County.....

Registration District No. **1008**

Township.....

Primary Registration District No. **1008**

City *St. Louis* (No. *East Route to Hazel*)

File No. ....

Registered No. **5870**

St. .... Ward)

2. FULL NAME *Mary Walker*

(a) Residence, No. *2619 S. Adams* St. *22* Ward. (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 *Col.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Anna Walker*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1892*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min. *Abt. 44*

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Prof.* 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *House Keeper* 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) *Lynn Ark*

FATHER 13. NAME (Name) *Jones*

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

MOTHER 15. MAIDEN NAME *Johnson*

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

17. INFORMANT (ADDRESS) *Anna Walker*

URIAL, CREMATION, OR REMOVAL PLACE *First Baptist Church* DATE *June 7th, 1936*

NDERTAKER (ADDRESS) *J. W. Bruce*

ILED JUN 6 1936 *J. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5/31/1936*

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 *12:30* p.m.

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

*Coronary Occlusion  
Cardiac hypertrophy  
Chronic Nephroses*

Other contributory causes of importance: *131*

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

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

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) *Herald B. Jones* M. D. (Address) *St. Louis*

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ITH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

