

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MICHIGAN STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37023

Dr. Williams
Registration District No. D 750

Primary Registration District No. 205985

Registrar's No. 1629

1. PLACE OF DEATH:

(a) County Ripley Co

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs & 7 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ripley

(c) City or town Doniphan, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME BERTHA MAE WALKER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Jesse C. Walker

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Nov 30 1881
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30 year 1939 hour 9 minute 20 P.

21. I hereby certify that I attended the deceased from September 25, 1939, to September 30, 1939, that I last saw him alive on September 25, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years 58 Months 10 Days _____ If less than one day _____ min.

9. Birthplace Evansville Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER

12. Name Jacob Brewer

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Anna Miller

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Immediate cause of death Endo Carditis

Due to Multiple Carbuncles on neck + back

Due to _____

Other conditions 90%
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature G. C. Walker

(b) Address Doniphan, Mo

17. (a) Burial (b) Date whereof Oct 3-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Doniphan Cemetery

18. (a) Signature of funeral director Jesse Shelby

(b) Address East Doniphan, Mo

19. (a) 10-5-1939 (b) C. B. Johnston
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. Williams (M. D. or other) _____

Address Doniphan, Mo Date signed 10-6-39

50M-5-17-39
Rev. 5-17-39
U. S. G. P. 1 X1931

4/28/39
J.H.S.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under the personal supervision.

District Health Officer No. 5.

District File Number 1139423

Date Filed 11/3/39

Signed.....

Licensed Embalmer No. 2726

P. O. Address East Prairie, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

37023
Do not use this space.

1. PLACE OF DEATH

(a) County Ripley Registration District No. 750
(b) Township Douglas Primary Registration District No. 3983
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bertha May Walker

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-30-1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 10 -

8. Trade, profession, or particular kind of work done as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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).....

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS).....

20. FILED 103 - 39 W. J. Johnston Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from to , 1939

I last saw him alive on , 1939. 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

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....., 1939

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 J. E. Williams, M. D.

(Signed) W. J. Johnston (Address) Douglas Mo

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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