

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 9991Registration District No. 4Primary Registration District No. 3001Registrar's No. 67

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: County Nurse Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution from Aug
 In this community 6 1939 to Mar 19 1940
 years, months or days (Specify whether)

8. (a) PRINT FULL NAME Miles Walker8. (b) If veteran, name war X 8. (c) Social Security No. X4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife Emma Walker 6. (c) Age of husband or wife if alive 7 years7. Birth date of deceased Aug. 29 1858 (Month) (Day) (Year)8. AGE: Years 81 Months 7 Days 19 If less than one day min.9. Birthplace Scioto Co Ohio (City, town, or county) (State or foreign country)10. Usual occupation Mechanic

11. Industry or business

12. Name Joseph and Josephine Walker13. Birthplace Scioto Co Ohio (City, town, or county) (State or foreign country)14. Maiden name Josephine Miles
15. Birthplace Scioto Co Ohio (City, town, or county) (State or foreign country)16. (a) Informant X Russell Walker(b) Address Macomb17. (a) Burial (b) Date thereof 9-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Macomb Ill18. (a) Signature of funeral director Robert Lipper(b) Address Highway 20019. (a) 3-21-40 (b) Spencer A. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town Kirksville, Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 916 E. Harrison St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 40 hour 7 minute 10 A.M.21. I hereby certify that I attended the deceased from Aug 6
1939 to Mar 19 1940;
that I last saw him alive on Mar 18 1940
and that death occurred on the date and hour stated above.Immediate cause of death Bronchial Pneumonia Duration 2 weeksDue to infirmitiy of ageDue to 107 1/2Other conditions Stokes Adams Syndrome
(Include pregnancy within 3 months of death)Senile dementia - refusal to eatMajor findings: Senile dementia - refusal to eat

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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? _____

3 While at work? _____ (Specify type of place) (e) Manner of injury 523. Signature Spencer A. Freeman (M. D. or other) MDAddress Kirksville Date signed 3/19/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 4-40-859

Date Filed APR 16 1940

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 my personal supervision.

Signed E. E. H. [Signature]

Licensed Embalmer No. 878

P. O. Address.....

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.