

FILED MAY 8 1940

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

16313
Do not use this space.

1. PLACE OF DEATH

(a) County Stone Registration District No. 845
(b) Township Jamez Primary Registration District No. 6109 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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

426 L.C. Walker Leighton C. Walker
(a) Residence, No. 7mi. S. Reeds Springs St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Clara Walker
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-19-1867
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 72 8 3
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Farm
10. Date deceased last worked at this occupation (month and year) 1938 11. Total time (years) spent in this occupation. Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wilmington, Del.

FATHER 13. NAME Henry Walker

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

MOTHER 15. MAIDEN NAME Margaret Schofield

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Mrs. L.C. Walker
Reeds Springs, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Edwards Cem. DATE 2-25-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. Stultz
Reeds Springs, Mo.

20. FILED Apr 30 1940 L.S. Skumate
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-24-40

22. I HEREBY CERTIFY, That I attended deceased from June 1938, to Feb. 1940

I last saw him alive on 2-21-1940. Death is said to have occurred on the date stated above, at 7:20 A.M.

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

Addisons disease

Date of onset ?

Other contributory causes of importance:

None

Name of operation None Date of _____

What test confirmed diagnosis? No 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 _____

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) W.P. Cottrell, M. D.
(Address) Reeds Springs, Mo.

WHILE EXAMINING 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.

RECEIVED

District Health Officer No. 6,

District File Number 540-1226

Date Filed MAY 6 1944

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.....

Licensed Embalmer No.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16319

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 845

Primary Registration District No. 6109

Registrar's No.

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

1. PLACE OF DEATH

(a) County Stone
(b) ~~City~~ James T. Ia
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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

Lightfoot, Walker

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 24
year 1940 hour minute M.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Date received local registrar (b) Registrar's signature

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 W. C. Cottrell (M. D. or other)

Address Reed Springs, Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

