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

FILED JUN 17 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17652

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2179

1. PLACE OF DEATH

(a) County: Jackson
(b) City or town: Kan City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1108 E 16 St 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days): Unknown
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson
(c) City or town: Kan City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1108 E 16 St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ... years.

3. (a) PRINT FULL NAME: John H. Walker 426
3. (b) If veteran, name war: no
3. (c) Social Security No.: —
4. Sex: Male
5. Color or race: Col
6. (a) Single, widowed, married, divorced: Unk
6. (b) Name of husband or wife: X
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Unknown (Month) (Day) (Year)
8. AGE: Years 46 Months Days If less than one day hr. min.
9. Birthplace: Camden (City, town, or county) Ark (State or foreign country) 1
10. Usual occupation: Fisher 1
11. Industry or business: —
MOTHER FATHER
12. Name: Odie Walker 9
13. Birthplace: Camden (City, town, or county) Ark (State or foreign country) 1
14. Maiden name: —
15. Birthplace: — (City, town, or county) (State or foreign country)
16. (a) Informant: Rev. Holland
(b) Address: 617 E 14 St
17. (a) College of Osteopathy (Burial, cremation, or removal) (b) Date thereof: 5-28-40 (Month) (Day) (Year)
(c) Place: burial or cremation: 2605 Indep.
18. (a) Signature of funeral director: Ideal Fun. Home
(b) Address: 1409 E 12 St
19. (a) May 27, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 14 year 1940 hour ... minute ... M.
21. I hereby certify that I attended the deceased from ... 19..., to ... 19..., that I last saw him alive on ... 19..., and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Pulmonary Edema
Due to: Hypostatic Myocardi
Due to: 3 yr 9 m
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: Of autopsy:

Duration

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury: 1
23. Signature: [illegible] (M. D. or other)
Address: [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 L. P. Harris Sr.

Licensed Embalmer No. 3388

P. O. Address K. C. Mo.

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

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