

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

24766
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 177
 (c) City Fulton (d) Street No. Callaway Hospital 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 Ms. Hazel Walker Williams
 (a) Residence, No. Kansas City Mo St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** Negro **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)** Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18-1912

7. AGE YEARS 28 MONTHS 0 DAYS 29 If LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) Fulton Mo

FATHER
 13. NAME Clyde E. Walker
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fulton Mo

MOTHER
 15. MAIDEN NAME Kustina Parker
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

17. INFORMANT (ADDRESS) Ms. Kustina Johnson
Fulton, Mo

18. BURIAL, CREMATION, OR REMOVAL Interred Fulton, Mo DATE July 20, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. L. Ball
Fulton, Mo

20. FILED July 18, 1940 R. N. Crew
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17-1940

22. I HEREBY CERTIFY That I attended deceased from 6-14, 1940, to 6-17, 1940
 I last saw her alive on 6-17, 1940. Death is said to have occurred on the date stated above, at 6:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Primary Tuberculosis
Tubercular Hypost. Spine

Date of onset 1932

Other contributory causes of importance:
Arteriosclerosis of the
years ago.

Name of operation Salt Date of Mo
 What test confirmed diagnosis? Salt 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....., 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? No
 If so, specify.....
 (Signed) R. N. Crew, M. D.
 (Address) Fulton, Mo

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.

No Security Number

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..... *Dr. Bee*

Licensed Embalmer No. *2730*

P. O. Address..... *Delta 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.