

Registration District No. **784**

Primary Registration District No. **200**

1. PLACE OF DEATH:
(a) County. **St. Louis County**
(b) City or town. **Jefferson Barracks**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **Admitted 6/14/40.**
(Specify whether
In this community. **3**
years, months or days)

3. (a) PRINT FULL NAME **Ira W. Walker 426**
3. (b) If veteran, name war **World War**
3. (c) Social Security No. **yes "Not remembered"**

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **February 20 1889**
(Month) (Day) (Year)

8. AGE: Years **51** Months **4** Days **25**
If less than one day hr. min.

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

10. Usual occupation **Musician.**

11. Industry or business **-**

12. Name **Alfred Walker**

18. Birthplace **Unavailable Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Fannie Henderson**

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

16. (a) Informant **M. Schellig**
(b) Address **Clinical Clerk, VAF, Jeff. Bks., Mo.**

17. (a) **Removal** (b) Date thereof **7-16-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Alton, Illinois**

18. (a) Signature of funeral director **Charles J. Gates**

(b) Address **4107 Finney Avenue**

19. (a) **JUL 16 1940** (b) Registrar's signature **[Signature]**
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **IND**
(c) City or town **Alton**
(If outside city or town limits, write "RURAL")
(d) Street No. **920 Highland Avenue.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **-** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15 th**
year **1940** hour **9:10** minute **8 a.m.**

21. I hereby certify that I attended the deceased from **June 14, 1940**, to **July 15, 1940**
that I last saw him alive on **July 15, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis, chronic, active, far advanced (C).**

Due to **-**

Due to **-**

Other conditions **None.**
(Include pregnancy within 3 months of death)

Major findings: Of operations **-**

Of autopsy **No autopsy.**

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

(a) Accident, suicide, or homicide (specify) **No**

(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? **Yes** (Specify type of place) (Specify type of injury)

23. Signature **C. W. HUGHES, M.D.** (M. D. or other) **1**

*Address **Chief Medical Officer** Date signed

Duration **unkn.**
PHYSICIAN **-**
Underline the cause to which death should be charged statistically.

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

AUG 13 1941

STATEMENT BY LICENSED EMBALMER

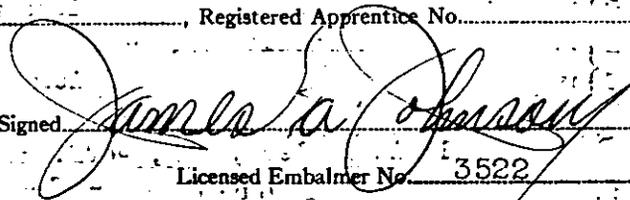
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

James A. Johnson

, Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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

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

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