

S. No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38518**

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. **296**

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

DECLARATION OF DEATH:

(a) County **Cole**

(b) City or town **Jefferson City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Mo. State Penitentiary Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In ~~XXXX~~ hospital or institution **5 years**
(Specify whether Same) (Specify whether years, months or days) **3**

3. (a) PRINT FULLNAME **GERALD WALKER (47009)**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **Male** 5. Color or race **White** 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 10, 1910**
(Month) (Day) (Year)

8. AGE: Years 30	Months 09	Days 10	If less than one day hr. _____ min.
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9. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER { 12. Name **Unknown**

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

{ 14. Maiden name **Unknown**

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

16. (a) Informant **Dr. Marshall W. Kelly**
(b) Address **Jefferson City, Mo.**

17. (a) **Removal** (b) Date thereof **11-14-40**
(Burial, cremation, or removal) **New Madrid** (Month) (Day) (Year)

(c) Place: burial or cremation **New Madrid, Mo.**

18. (a) Signature of funeral director **Dawson-Tanner**
(b) Address _____

19. (a) **11-14-40** (b) **Dr. Kelly**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**

(c) City or town **New Madrid**
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** 12th 1940
year **1940** hour **8:00 PM** Date **Nov. 12th, 1940**

21. I hereby certify that I attended the deceased **Nov. 12th, 1940**
Him **November 12th, 1940**
that I last saw h **alive** on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Accidental Death, 3rd Degree Burn, by live steam while scaling drum of boiler, entire body**

Due to **scaling drum of boiler, entire body**

Due to **burned**

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

Major findings: **none**

Of operations **none**

Of autopsy **none**

PHYSICIAN _____
Underline the cause to which death should be charged etiologically.

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

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **Nov. 12, 1940**

(c) Where did injury occur? **In Prison Jefferson**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Prison
(Specify type of place)

While at work? **yes** (Specify type of place) (b) Means of injury **Burned**

23. Signature **Thas Michel Coroner** (M. D. number) _____
Address **Jefferson Mo.** Date signed **11-12-40**

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. 3641

P. O. Address Jefferson City

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, fact should be so stated above.