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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 16 1942

Registration District No. 837

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6099

State File No. 8045

Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Bloomfield, Rural (If outside city or town limits, write "RURAL" and name of township)
(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 ----- In this community 2 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Stoddard
(c) City or town: Bloomfield, Mo. Rural (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: Mary Genice Walker
3. (b) If veteran, name war: ----
3. (c) Social Security No.: ----
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Infant
6. (b) Name of husband or wife: ----
6. (c) Age of husband or wife if alive: -- years
7. Birth date of deceased: Nov. (Month) 29 (Day), 1941 (Year)
8. AGE: Years ---, Months 2, Days 7, If less than one day ___ hr. ___ min.
9. Birthplace: Bloomfield, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: ----
11. Industry or business: ----
12. Name (Father): Raymond G. Walker
13. Birthplace (Father): Bloomfield, Mo. (City, town, or county) (State or foreign country)
14. Maiden name (Mother): Frankie Barker
15. Birthplace (Mother): Stoddard county, Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: Raymond G. Walker
(b) Address: Bloomfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 7-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Walker cemetery
18. (a) Signature of funeral director: Chiles Und. Co.
(b) Address: Bloomfield, Mo.
19. (a) Feb. 17, 1942 (Date received local registrar) (b) Pearl Elmore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6th year 1942 hour 3:15 minute P. M.
21. I hereby certify that I attended the deceased from FEB. 3, 1942 to FEB. 6, 1942 that I last saw her alive on FEB. 6, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
BRONCHIAL PNEUMONIA	4 DAYS
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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
23. Signature: [illegible] M.D. (M. D. or other)
Address: BLOOMFIELD Date signed 2-9-42

11-20 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 342/346
Date Filed 3/10/42

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 Infant was not embalmed.

Licensed Embalmer No. .....

P. O. Address .....

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, fact should be so stated above.

No. 2B
—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8045

Registration District No. 827 Primary Registration District No. 6099 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Mary G. Walker
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Nov (Month) 29 (Day) 1941 (Year)
8. AGE: Years — Months 2 Days (If less than one day) hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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)

MEDICAL CERTIFICATION

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

Immediate cause of death	Duration
PRIMARY: Bronchial Pneumonia	
Due to: UNCOMPLICATED	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 107	
Of autopsy	

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed