

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 3 year (Yes or No)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 222 1/2 West
(If rural, give location)

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

3. (a) PRINT FULL NAME Lestie L. Walker

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1943 hour 3 minute 7 M.

21. I hereby certify that I attended the deceased from June 17, 1943, to June 16, 1943
that I last saw him alive on June 16 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of face 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
(Day) (Year)

7. Birth date of deceased 3-8-1939
(Month) (Day) (Year)

Immediate cause of death Peritonitis (uremia) Duration 1 week

Due to _____

Due to S. 1/2 9

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
3 8 10 8 hr. min.

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation baby

Major findings:
Of operations _____

Of autopsy _____

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

MOTHER FATHER {

11. Industry or business _____

12. Name James L. Walker

13. Birthplace Bates Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Joslin

15. Birthplace Hambler Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Joslin

(b) Address 222 1/2 West

17. (a) Burial (b) Date thereof 1-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mem Park

18. (a) Signature of funeral director J. H. Daniels

(b) Address 74 Kansas St

19. (a) 1-20-43 (b) M. M. Corum
(Date received local registrar) (Registrar's signature)

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature E. S. ... (M.D. or other) _____
Address 307 W 47 Date signed 1/22/43

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. 2598
working under my personal supervision.

Signed Chuck Werner
Licensed Embalmer No. 2598
P. O. Address R C Kansas

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 304

Registration District No. _____

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Leslie L Walker

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

4. Sex M 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ 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) 7/20/48 (Date received local registrar) (b) L. M. Osame (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. 2221 1/2 Troch
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

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 him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: hepatic - uremia

Due to: specimen of upper respiratory tract 4 weeks

Due to: r 13/00

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy: Chronic glomerulonephritis, Ac. dilatation of heart, Emphysema of lungs

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Esther J. Silver (M. D. or other)

Address 304 17th St Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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