S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7105

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 3

72
1
0

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

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: 1 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid 72 1 0

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

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Max Aaron Walker

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 0

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased April (Month) 11 (Day) 1936 (Year)

8. AGE: Years 6 Months 9 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Piggott, (City, town, or county) Ark. 1 (State or foreign country)

10. Usual occupation Student in school

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country) 9

MOTHER
14. Maiden name Marcella Walker ~~St. Cin~~
15. Birthplace Rector, (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant Marcella Walker, St. Cin

(b) Address Gideon, Mo.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield Cem.

18. (a) Signature of funeral director Lloyd Russell

(b) Address Piggott, Ark.

19. (a) Jan. 27-43 (Date received local registrar) (b) Freida Macom (Registrar's signature)

MEDICAL CERTIFICATION 1-25-43

20. DATE OF DEATH: Month June day 25/43 year 1943 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 24, 1943 to Jan 25, 1943 that I last saw him alive on June 25, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death ~~[illegible]~~ Mumps and Pneumonia

Due to .....

Due to .....

44c

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy None

Duration

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) ~~[illegible]~~

(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. or other)

Address [illegible] Date signed Jan 26

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 243-24
Date Filed 2-8-43

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.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.