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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 29 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20910
Registrar's No. 626-

Registration District No. 72

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
In this community 75 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11
(c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No. 1224 North 17th 7
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME SYLVIA ANN WALKER

3. (b) If veteran, name none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Eugene Walker 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct. 22 1358
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 7 9 hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Wm. A. Predmore
13. Birthplace unknown Ohio 1
(City, town, or county) (State or foreign country)
14. Maiden name Zina Van Leuven
15. Birthplace unknown Illinois 1
(City, town, or county) (State or foreign country)

16. (a) Informant Lloyd A. Walker
(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 6/2/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Heaton - Bittel & Bowman
(b) Address St. Joseph, Mo.

19. (a) 6/1/43 (b) Rae Helgoy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1943 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from May 12 1943 to May 31 1943
that I last saw her alive on May 31 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture neck of femur - right anterior sclerosis general
Due to Fracture neck of femur - right anterior sclerosis general
Due to Fracture neck of femur - right anterior sclerosis general

Other conditions Plural effusion - left
(Include pregnancy within 3 months of death)

Major findings: Of operations 186/10
Of autopsy 186/10

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) Accident 131
(b) Date of occurrence May 12, 1943
(c) Where did injury occur? In home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
St. Joseph Buchanan Co Mo
(Specify type of place) (e) Means of injury Fall
While at work? no
23. Signature R. B. Lenton (M. D. or other) MD
Address St. Joseph, Mo Date signed 6-2-43

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

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 *James A. Moles*
Licensed Embalmer No. *3296*
P. O. Address *St Joseph Mo*

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hosp
(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 _____ (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 Sylvia Ann 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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 22 (Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 9 If less than one day _____ min.

9. Birthplace near Rockwell Station, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Rose Herzog (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Year 1940 Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I have seen him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



