

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:  
**Robinson Sanitarium**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 weeks**  
(Specify whether years, months or days)

In this community **since 1931**

3. (a) PRINT FULL NAME **Mrs. Marjorie M. Walker**

3. (b) If veteran, name war **NO.**

3. (c) Social Security No. **NO.**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **C. A. L. Walker**

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

7. Birth date of deceased **December 2 1895**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**47 9 3** hr. min.

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

10. Usual occupation **at home**

11. Industry or business **X**

12. Name **Dr. George N. Macomber,**

13. Birthplace **New York,**  
(City, town, or county) (State or foreign country)

14. Maiden name **Minnie Adams,**

15. Birthplace **New York,**  
(City, town, or county) (State or foreign country)

16. (a) Informant **C. A. L. Walker,**

(b) Address **6828 Cherry, Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **9-8-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: **St. Moriah**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **9-8-43** (b) **J. E. Brown**  
(Date received in) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson,** **48**

(c) City or town **Kansas City,** **3**  
(If outside city or town limits, write "RURAL") **0**

(d) Street No. **6828 Cherry**  
(If rural, give location)

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

If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **5th**  
year **1943** hour **10** minute **20** M.

21. I hereby certify that I attended the deceased from **Aug 14** 19**43**, to **Sept 5** 19**43**;  
that I last saw him alive on **Sept 9** 19**43**;  
and that death occurred on the date and hour stated above.

Immediate cause of death: **acute dilatation of heart** **6 hrs.**  
Duration

Due to **myocardial infarction** **2-3 days**

Due to **dissecting aortic aneurysm** **4 hrs.**

Other conditions: **hypertension**

(Include pregnancy within 3 months of death)

Major findings: **95c** **4** **PHYSICIAN**  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
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 **J. E. Brown** (M. D. or other) **0**  
Address **1412 Prof. Bldg. K.C., Mo.** Date signed **9-7-43**

Dr. Lendis B. Elliott Ha 6234

*Prof Beddy*

*Embalmed  
Mellon*

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**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 *E. M. Plank*

Licensed Embalmer No. *1848*

P. O. Address *K. C. 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.**