

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

32385  
Do not use this space.

FILED OCT 13 1943

1. PLACE OF DEATH

(a) County Reynolds Registration District No. 299  
(b) Township Black River Primary Registration District No. 6026 Registered No. 90  
(c) City ..... (d) Street No. .... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Jan Edward Walker St.  (If nonresident, give city or town and State) 0  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min. 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) near Black (STATE OR COUNTRY) Reynolds Co. Mo.

FATHER 13. NAME Jimmie Walker  
14. BIRTHPLACE (CITY OR TOWN) Westernville (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Sarah Gaye Hawkins  
16. BIRTHPLACE (CITY OR TOWN) Black (STATE OR COUNTRY) Mo.

17. INFORMANT Sarah Hawkins (ADDRESS) Black Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE near Black DATE 8/26 1943

19. FUNERAL DIRECTOR (NAME) none (ADDRESS) \_\_\_\_\_

20. FILED Oct 7 1943 Joe Doney Wellington Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 25 1943

22. I HEREBY CERTIFY, That I attended deceased from Aug 23 1943, to Aug 25 1943  
I last saw him alive on Aug 25 1943 Death is said to have occurred on the date stated above, at 6:23 a.m.  
The principal cause of death and related causes of importance were as follows:

wrapped cord unable to deliver in time to prevent death Date of onset \_\_\_\_\_

Other contributory causes of importance: 1600

Name of operation Forceps delivery Date of \_\_\_\_\_ 8/25/43  
What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) E. Nestor Patrick M. D.  
(Address) Perleth, Mo.

1194

DECEMBER 1943  
District Health Officer No. 5  
District File Number 1048616  
Date Filed 10-9-43

**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, above space should be left blank.**