

S. No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

48819

State File No. _____

Registrar's No. 107

FILED JAN 14 1944

Registration District No. 120

Primary Registration District No. 4196

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

1. PLACE OF DEATH:

(a) County Sevier
(b) City or town Darlington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: _____ (Specify whether
In this community _____ years, months or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sevier
(c) City or town Darlington
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wilson Elsworth 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 Married
6. (b) Name of husband or wife Mabel E. Crawns 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased January 15 1864
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name James Walker
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Mabel E. Crawns
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. E. Walker

(b) Address Darlington, Mo.

17. (a) Resident (b) Date thereof 12/5/43
(Residential, occupation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankfort, Ind.

18. (a) Signature of funeral director W. H. Adams
(b) Address Albany, Mo.

19. (a) 12/7/43 (b) W. H. Adams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from October 9th 1943 to Dec 2nd 1943
that I last saw him alive on Dec 2nd 1943
and that death occurred on the date and hour stated above.

Immediate cause of death acute cerebral hemorrhage
Due to Arteriosclerosis
1. Coronary Arteriosclerosis

Duration 4 days

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

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 W. S. Campbell (M. D. or other) MD
Address Albany Mo Date signed 2nd

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed Clifford Bruck

Licensed Embalmer No. 3329

P. O. Address Albany, Md

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.