

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.

FILED FEB 9 1944

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

2500  
Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 70  
(b) Township Des Moines Primary Registration District No. 4123 Registered No. 15  
(c) City Wayland, (d) Street No. 1 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

Janice Sue Walker  
(a) Residence, No. Wayland, Mo. St.  (If nonresident, give city or town and State) Mo.  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 5 1943  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2 12  
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 \*  
OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) Wayland  
(STATE OR COUNTRY) Missouri

13. NAME Lloyd Walker  
14. BIRTHPLACE (CITY OR TOWN) Revere  
(STATE OR COUNTRY) Mo.

15. MAIDEN NAME Lena Poice  
16. BIRTHPLACE (CITY OR TOWN) Revere  
(STATE OR COUNTRY) Mo.

17. INFORMANT Miss Lloyd Walker  
(ADDRESS) Wayland, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Revere, Mo DATE 1-10-1944

19. FUNERAL DIRECTOR (NAME) H. F. Kischer  
(ADDRESS) Wayland, Mo.

20. FILED 1-19-44 Perry's Barton  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 17 44

22. I HEREBY CERTIFY, That I attended deceased from 1-1-, 1944, to 1-17, 1944  
I last saw her alive on 1-16-, 1944. Death is said to have occurred on the date stated above, at 5:30 A.

The principal cause of death and related causes of importance were as follows:

CONVULSIONS FROM CALCIUM DEFICIENCY PREMATURE.

Date of onset

Other contributory causes of importance: 46

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury

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) S. H. Channing, M.D.

(Address) Raymond, Mo.

RECEIVED  
District Health Officer No. 10  
District File Number 2-44-346  
Date Filed FEB 8 1944

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, <sup>Not</sup> \_\_\_\_\_

or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 2611

P. O. Address Wayland

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.