

FILED MAY 1 1944

Registration District No. 199

Primary Registration District No. 4287

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Troy  
(If outside city or town limits, give "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: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community In this community (Specify whether)  
years, months or days 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln<sup>57</sup>

(c) City or town Troy Mo.  
(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 AVERY WALKER

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 8 1881  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>10</u>	<u>20</u>	hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Louis Walker

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

14. Maiden name Elizabeth Walker

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

16. (a) Informant Mary Walker

(b) Address Troy Mo.

17. (a) Burial (b) Date thereof 3/1/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy Cem.

18. (a) Signature of funeral director W. J. M. S. G.

(b) Address Troy Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28  
year 1944 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 14  
1938 to Feb. 28, 1 1944  
that I last saw him alive on Feb. 28 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the throat  
Duration 6 years

Due to \_\_\_\_\_  
Due to H5f  
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 Dr. J. J. Allevato (M. D. or other)  
Address Winfield, Mo. Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 4 28 44

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. 3584

P. O. Address Troy Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. may  
Registrar's No. \_\_\_\_\_

Registration District No. 179 Primary Registration District No. 4287

1. PLACE OF DEATH:

(a) County Lincoln  
(b) City or town Tray  
(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: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Avery Walker  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 8 1944  
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 15 (less than one day) \_\_\_\_\_ min.

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

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Mar 22-44 (b) Mrs. Fly Jackson  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

15116