

DEPARTMENT OF COMMERCE
 STATE OF MISSOURI
FILED JUN 29 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21237**

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

2-41
-39
K29484

Registration District No. **47** Primary Registration District No. **3008** Registrar's No. **193**

1. PLACE OF DEATH:
 (a) County Calloway
 (b) City or town Fulton Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital no. 1
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution 1 yr. 26 days
 (Specify whether years, months or days) 26 days
 In this community one year 26 days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Greene 14
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL") 2
 (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 Winston Walker
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race colored
 6. (a) Single, widowed, married, divorced, single
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 21 1906
 (Month) (Day) (Year)

8. AGE: Years 37 Months 1 Days 15
 If less than one day _____ hr. _____ min.

9. Birthplace Springfield Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____
 12. Name OK
 13. Birthplace OK (City, town, or county) (State or foreign country)
 14. Maiden name OK
 15. Birthplace OK (City, town, or county) (State or foreign country)

16. (a) Informant Anna Walker
 (b) Address 2409 Church St. Kansas City, Mo

17. (a) Removed (b) Date thereof 6-7-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director J. H. Campbell
 (b) Address Springfield Mo

19. (a) 6-7-1944 (b) James M. ...
 (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 6
 year 1944 hour 11 minute _____ A. M.
 21. I hereby certify that I attended the deceased from Feb 1
1944 to June 6, 1944
 that I last saw him alive on June 6, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheric meningitis encephalitis
 Due to Diphtheria of central nervous system
Aspirin

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

Major findings: Of operations _____
 Of autopsy _____
 30 h

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 James M. ... (M. D. or other)
 Address Fulton Mo Date signed 6/6/44

PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

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 W. P. Campbell
Licensed Embalmer No. 1747
P.O. Address Springfield 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.