S. No. 2
M—5-43
. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30350

FILED SEP 26 1944

Registration District No. 4449 Primary Registration District No. 1002 Registrar's No. 3755

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 4628 E. 8th (If rural, give location)
(e) Citizen of foreign country? (Yes or No): 0
If yes, name country:

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3. (a) PRINT FULL NAME: Ida Lou Walker
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: Femal
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: George Walker
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Apr. (Month) 21 (Day) 1891 (Year)

8. AGE: Years	Months	Days	If less than one day
53	4	21	hr. min.

9. Birthplace: (City, town, or county) alabama (State or foreign country)
10. Usual occupation: at home
11. Industry or business:
MOTHER FATHER
12. Name: William Jackson
13. Birthplace: (City, town, or county) Alabama (State or foreign country)
14. Maiden name: Mary Jane Smith
15. Birthplace: (City, town, or county) alabama (State or foreign country)
16. (a) Informant: Mrs Marion B Wagoner
(b) Address: 4628 E. 8th
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9 16 44 (Month) (Day) (Year)
(c) Place: burial or cremation: Floral Hills
18. (a) Signature of funeral director: Mrs. C. P. Forster
(b) Address: 914 Brooklyn
19. (a) 9-16-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 12 year: 1944 hour: 10 minute: 30 a.m.
21. I hereby certify that I attended the deceased from June 3 1944 to Sept 12 1944 that I last saw him alive on Sept 12 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Post-Operative Hemorrhage	3 days
Due to Uremia (n.m.d.)	[illegible]
Due Myocardial Damage	3 yrs
Other conditions: (Include pregnancy within 3 months of death) 63-21	
Major findings: Of operations Large Hiatus	
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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: [illegible] (M.D. or other)
Address: [illegible] Date signed: 9/15/44

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.

S. No. 2B
1—2-21-40
Vol X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3755

1. PLACE OF DEATH:

(a) County

(b) City or town (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 years, months or days)

In this community

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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ida Lou Walker

3. (b) If veteran, name war

3. (c) Social Security No. 492-14-3332

4. Sex Female

5. Color or race Wh

6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

MOTHER

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) 9-28-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. W. Buckingham (M. D. or other)

Address Date signed

SUPPLEMENTARY

30350