

FILED OCT 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33478

State File No. _____

4058

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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. Joseph Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 1 week (Specify whether)
In this community 35 years, years, months or days

3. (a) PRINT FULL NAME Walter C. Walker
3. (b) If veteran, name war no.
3. (c) Social Security No. 486-07-1193

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Lucile Walker
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased April 5 1890
(Month) (Day) (Year)

8. AGE: Years 54 ~~55~~ Months 5 Days 30 ~~29~~ hr. min.

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

10. Usual occupation Motion Picture Operator

11. Industry or business X

MOTHER FATHER { 12. Name William S. Walker
13. Birthplace unknown, (City, town, or county) (State or foreign country) IA
14. Maiden name Ida Bishop
15. Birthplace unknown, (City, town, or county) (State or foreign country) IA

16. (a) Informant Mrs. Lucile Walker
(b) Address 2540 Drury Ave., Kansas City, Mo.

17. (a) Burial (b) Date thereof 10-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 10-9-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2540 Drury Avenue,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X IA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4th
year 1944 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 18 1944 to Oct. 4 1944
and that death occurred on the date and hour stated above.
Duration 18 days
Immediate cause of death _____

Due to Chronic Valvular Heart Disease

Due to with myocardial degeneration

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Of operations 92
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 0

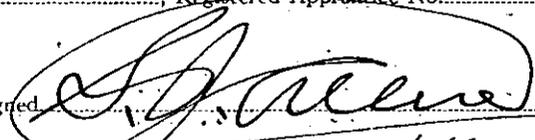
23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 10-7-44

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

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. 1415

P. O. Address. K. C. 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.