

Primary Registration District No. 1000

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether
 In this community 7 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan 11
 (c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL") 7
 (d) Street No. 3211 Seneca
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country U

3. (a) PRINT FULL NAME Carey T. Walkup
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 13
 year 1944 hour 5 minute 37 A. M.

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Louise T. Walkup
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased August 13 1380
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from see 10, 1944, to see 12, 1944
 that I last saw him alive on see 12, 1944
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>4</u>	<u>0</u>	<u>hr. min.</u>

Immediate cause of death Coronary atherosclerosis
 Duration 4 days

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

Due to Heart disease at 60 3yr
 Due to _____

10. Usual occupation retired Mach. Shop Operator

Other conditions 93d
(Include pregnancy within 3 months of death)

11. Industry or business
 12. Name William Riley Walkup
 13. Birthplace unknown Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown Oregon
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. C. T. Walkup
 (b) Address 3211 Seneca
 17. (a) removal (b) Date thereof 12/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Clinton, Mo.

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? _____

18. (a) Signature of funeral director Walter A. Bowman
 (b) Address 319 So. 10th
 19. (a) 12/14/44 (b) Walter A. Bowman
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature Dr. Harrison (M. D. or other) MD
 Address St. Joseph, Mo. Date signed 12-13-44

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

JUL 14 1949

Dr. J. H. Fussen
1 Kirk. Bldg.

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.