

S. 1. 2
M-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38674**

FILED DEC 28 1945
Registration District No. **319**

Primary Registration District No. **6078**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town INDIAN JACKSON T.S.
(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

3. (a) PRINT FULL NAME ARCHIE JOSEPH WALKER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased NOV. 27 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>3</u> hr. <u>30</u> min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name FRANCIS WALKER

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

14. Maiden name ARNEBIA STELEIGH COLMAN

15. Birthplace REYNOLDS CO. MO
(City, town, or county) (State or foreign country)

16. (a) Informant Francis Walker

(b) Address Bloomdale Mo

17. (a) BURIAL (b) Date thereof NOV 28 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BLOOMSDALE MO

18. (a) Signature of funeral director Geo. C. Risher

(b) Address St. Louis Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 95

(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 NOV day 27th
year 1945 hour 3:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from NOV 27
1945 to NOV 27 1945
that I last saw h. live on NOV 27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth.

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

151

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)

(c) Means of injury _____

23. Signature Arthur E. ... (M. D. or other) M.D.
Address St. Louis Mo Date signed 11-28-45

706

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 ^{mat.}.....
....., Registered Apprentice No.
working under my personal supervision.

Signed Geo C. Barber

Licensed Embalmer No. 1985

P. O. Address St. Genevieve 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.