S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40658

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1382

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: S.H. No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months (Specify whether
In this community 3 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Livingston
(c) City or town ~~St Joseph~~ Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No. 78 So. Cherry 7
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SHERMAN WALKER
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex M O
5. Color or race W
6. (a) Single, widowed, married, divorced Mar. 1
6. (b) Name of husband or wife Lena Brown Walker
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased ~~[illegible]~~ Dec. 18, 1885 (Month) Dec. (Day) 18 (Year) 1885

8. AGE: Years ~~[illegible]~~ 60 Months 0 Days 6 If less than one day hr. min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Wiley Walker
13. Birthplace Waldron Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Nora Crosby
15. Birthplace ? (City, town, or county) (State or foreign country)
16. (a) Informant Hospital record
(b) Address St. Joseph, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation Chillicothe Mo.
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph Mo.
19. (a) Dec. 26, 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1945 hour 3 minute a M.
21. I hereby certify that I attended the deceased from Dec 1 1945, 19..., to Dec 23, 1945 that I last saw him alive on Dec 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to Brain tumor
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 57

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? no (e) Means of injury
23. Signature F.A. Cannekarl (M.D. or other) MD
Address State Hosp. #2 St Joseph Date signed 12/24/45

1428

(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 Robert R. Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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.