S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34871

FILED SEP 21 1946

Registration District No. _____ Primary Registration District No. 6076 Registrar's No. 3023

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis Rural Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent's Sanitarium
(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 1 yr. 3 months 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Arkansas (b) County Washington
(c) City or town Springdale
(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 _____

3. (a) PRINT FULL NAME MR. THOMAS JEFFERSON WALKER
3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October (Month) 6 (Day) 1873 (Year)
8. AGE: Years 73 Months 0 Days 3 If less than one day _____ hr. _____ min.
9. Birthplace Lowell (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Farmer
11. Industry or business _____
12. FATHER Name Martin K. Walker
13. FATHER Birthplace _____ (City, town, or county) Virginia (State or foreign country)
14. MOTHER Maiden name Annie Van Winkle
15. MOTHER Birthplace _____ (City, town, or county) Arkansas (State or foreign country)
16. (a) Informant Mrs. T. J. Walker
(b) Address Springdale, Ark.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-10-46 (Month) (Day) (Year)
(c) Place: burial or cremation Rogers, Arkansas
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 10-14-46 (Date received local registrar) Ruth Allen M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9 year 1946 hour 8 minute 10 P.M.
21. I hereby certify that I attended the deceased from Dec 10, 1946, to Oct 9, 1946, that I last saw him alive on Oct 9, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Senile Psychosis & cerebral arteriosclerosis	
Due to	
Due to	
Other conditions generalized arteriosclerosis; cardio-vascular-renal disease	

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? —
While at work? — (Specify type of place) (e) Means of injury —
23. Signature S. R. Banet (M. D. or other) M.D.
Address 7300 St. Charles Rock Rd. Date signed 10-9-46

(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 Albert L. Hoppe

Licensed Embalmer No. 2971

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.