

FILED AUG 5 1947

State File No. _____

3050

Registration District No. 147

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 Kansas City Tuberculosis Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 73 days (Specify whether
In this community 73 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 538 Main St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Walker, John A.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if live _____ years (Day) (Year)

7. Birth date of deceased Jan 18 1877

(Month)

(Day)

(Year)

8. AGE:

Years 73

Months 5

Days 27

If less than one day

hr. _____ min. _____

9. Birthplace Kansas

(City, town, or county)

(State or foreign country)

10. Usual occupation Clerk

11. Industry or business not known

MOTHER FATHER

12. Name John Sharp Walker

13. Birthplace Princeton, Indiana

14. Maiden name Anna A. Hershey

15. Birthplace Iowa

16. (a) Informant Recd Clerk

(b) Address R.C. Hospital

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 7-19-47 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary, R.C. Hosp

18. (a) Signature of funeral director Walter Funeral Home

(b) Address R.C. Mo.

19. (a) 7-19-47 (Date received local registrar)

(b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1947 hour 19 minute 55 P. M.

21. I hereby certify that I attended the deceased from May 22 to July 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, tubercular

Duration 8 Mo

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: 136

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) Means of injury _____

23. Signature [Signature] (M. D. or other) MD

Address Kansas City Mo Date signed 7-15-47

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.....

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.