

S. No. 2
1-12-45
S-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26912

State File No. _____

FILED AUG 25 1947

Registrar's No. 978

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: State Hospital no 2
(d) Length of stay: In hospital or institution 5 yrs 9 mo. 14 days
In this community 5 yrs 9 mo. 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray
(c) City or town Garden
(d) Street No. ✓
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: Newt Walker

3. (b) If veteran, name war: WWK 3. (c) Social Security No.: 7W

4. Sex: male Color or race: white 5. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife: WWK 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Oct. 30 1874 (Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 4 If less than one day hr. min.

9. Birthplace: Harrisonville Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

12. Name: Rubin Walker 13. Birthplace: Harrisonville Mo (City, town, or county) (State or foreign country)

14. Maiden name: Amanda Bull 15. Birthplace: Harrisonville Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Ray County Court (b) Address: Richmond Mo

17. (a) Removal (b) Date thereof: 8-16-47 (Month) (Day) (Year) (c) Place: burial or cremation: Hardier Mes

18. (a) Signature of funeral director: Stanley Fernald Home (b) Address: St. Joseph Mo

19. (a) 8-15-47 (b) E. B. Jenkins (Date received local registrar) (Registrar signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14 year 1947 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 1, 1947, to Aug 14, 1947 that I last saw him alive on Aug 13, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to: Arterio Sclerosis

Due to: Other conditions: (Include pregnancy within 3 months of death)

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: U

23. Signature: Forrest Thomas (M. D. or other) Address: St. Joseph Mo Date signed: 8/14

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. *2435*

P.O. Address *St. Joseph*

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.