

National Office of Vital Statistics  
FILED MAY 13 1948  
Registration District No. 00

Primary Registration District No. 5725

State File No. 319  
Registrar's No. 319

1. PLACE OF DEATH:  
(a) County: Macon  
(b) City or town: Macon  
(c) Name of hospital or institution:  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Ma (b) County: Macon 61  
(c) City or town: Macon  
(d) Street No.: R7D.  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME: Gayette S. Walker  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: April day: 4<sup>th</sup>  
year: 1948 hour: 7 minute: 15 P.M.

4. Sex: M.O 5. Color or race: W  
6. (a) Single, widowed, married, divorced: M  
6. (b) Name of husband or wife: Ola Myrtle Walker  
6. (c) Age of husband or wife if alive: 70 years  
7. Birth date of deceased: Dec. 2 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 25, 1948, to April, 19.....  
that I last saw him alive on....., 19.....  
and that death occurred on the date and hour stated above.

8. 'AGE: Years Months Days If less than one day  
82 4 2 hr. min.

Immediate cause of death: Acute Myocarditis  
Due to: Senile Dementia  
Due to: Arterio Sclerosis  
Other conditions: (include pregnancy within 3 months of death)

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

10. Usual occupation: Farming  
11. Industry or business:  
12. Name: Robert Walker  
13. Birthplace: Penn  
14. Maiden name: Korunza E. Lawrence  
15. Birthplace: Ohio

PHYSICIAN  
Major findings: Of operations.....  
Of autopsy: 97  
Underline the cause of which death should be charged statistically.

16. (a) Informant: Ma Edith Kitzmann  
(b) Address: Macon, Mo.  
17. (a) Burial: Rural (b) Date thereof: 4-6-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Bethlehem Ch. Cem  
18. (a) Signature of funeral director: Stephen Standing  
(b) Address: Macon, Mo  
19. (a) 5-1-48 (b) Edith Mcnealy  
(Date received local registrar) (Registrar's signature)

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: R.L. Madder (M. D. or other) MD  
Address: Macon, Mo Date signed: 4/9/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10/

District File Number 54888

MAY 12 1948

Date Filed

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 \_\_\_\_\_

*James B. Cleaver*  
working under my personal supervision.

Registered Apprentice No. *515*

Signed *Robert Stephens*

Licensed Embalmer No. *3057*

P. O. Address *Macon, 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.

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Fayette S. Walker

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased see 2 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(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 April year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-13332