

FILED MAY 24 1948

Registration District No. 379

Primary Registration District No. 6286

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Mountain Grove Rural Wood Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 73 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Allen Walker

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Susan Walker 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased April 22 1864  
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mt vernon Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

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

MOTHER FATHER { 12. Name G. M. C. Walker  
13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Jane Dowden  
15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Walker  
(b) Address Mountain Grove, Mo

17. (a) Burial (b) Date thereof 1/22/1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Broyle Cemetery

18. (a) Signature of funeral director George Staff  
(b) Address Mountain Grove, Missouri

19. (a) 5-4-48 (b) A. L. Ames  
(Date received local registrar) (Registrar's signature) 2118

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright  
(c) City or town Mtn. Grove - Rural - Wood Twp.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 20th  
year 1948 hour 10 minute \_\_\_\_\_ P. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov 5  
1948 to Jan 20 1948  
that I last saw him alive on Jan 18 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure

Due to Brain

Due to arterial sclerosis

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 1/29

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

RECEIVED

District Health Officer No. 6,

District File Number 548-616

Date Filed MAY 20 1948

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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 *Burge Shepp*  
Licensed Embalmer No. 3161  
P. O. Address *Mr. James, Md*

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.