

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21864**

FILED JUL 14 1948

Registration District No. **398**

Primary Registration District No. **3073**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County Scott
 (b) City or town Chaffee
 (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 26 1/2 years (Specify whether
 *years, months or days)

3: (a) PRINT FULL NAME Robert Roy Walker

3. (b) If veteran, name war No 3. (c) Social Security No. 376-18-2473

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Graham Walker 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: Sep 3 1898
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 10 10 hr. min.

9. Birthplace 3ahna Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Construction Worker

11. Industry or business

12. Name A. Mos. Walker

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

14. Maiden name Nettie Vance

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

16. (a) Informant Mrs. R.R. Walker

(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 7-5-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cape Co Mo

18. (a) Signature of funeral director B. Splinghoff Funeral Home

(b) Address Chaffee Mo

19. (a) 7/6/48 (b) S. B. MacCreary
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100
 (c) City or town Chaffee 1
 (If outside city or town limits, write "RURAL") 1
 (d) Street No. 1
 (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
 year 1948 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 7/3, 1948 to 7/3, 1948
 that I last saw him alive on 7/3/48 and that death occurred on the date and hour stated above.

Immediate cause of death Large Crooked Hip & Leg
 Due to Said to be Carcinoma 2 Yrs
 Due to Anemia 6 Mos
 Other conditions Stenocardia
 (Include pregnancy within 3 months of death)

Major findings: Baptist Hospital
 Of operations St Louis
 Of autopsy 1947

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Not known
 (b) Date of occurrence 7/3/48
 (c) Where did injury occur? Chaffee Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? 0 (Specify type of place) (c) Means of injury 0

23. Signature S. B. MacCreary (M. D. or other)
 Address Chaffee Mo Date signed 7/6/48

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

MOTHER FATHER

RECEIVED

District Health Officer

District File Number 248-

Date Filed 2-12-

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 Mamie Dupleughoff

Licensed Embalmer No. 3242

P. O. Address Chaffee 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.