

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25412**
Registrar's No. **75**

FILED SEP 7 1948

Registration District No. **11**

Primary Registration District No. **5042**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Rural Liberty Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home 2 1/2 mi. S.W. Exeter, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **10 mo. 11 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **2 1/2 mi. S.W. Exeter, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Betty Ann Walker

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **S.**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 8, 1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 11 hr. min.

9. Birthplace **Barry County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Cliford Lynn Walker**

13. Birthplace **Fisher County, Texas**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Ellen Hugins**

15. Birthplace **Slaten County, Texas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Cliford L. Walker**

(b) Address **R.F.D., Exeter, Mo.**

17. (a) **Burial** (b) Date thereof **8/19/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maplewood Cemetery**

18. (a) Signature of funeral director **M.C. Noon**

(b) Address **1303 Main St., Cassville, Mo.**

19. (a) **Aug 23-48** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19**
year **1948** hour **4** minute **A.M.**

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

Immediate cause of death **congenital heart**
Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **1-5-10**

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? _____

(Specify type of place) While at work _____ (e) Means of injury _____

23. Signature **Glenn H. Salzer M.D.** (M. D. or other) _____

Address **Cassville Mo.** Date signed _____

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

300
47
39
9906

RECEIVED

District Health Officer No. 6,

District File Number 948-947

Date Filed SEP 3 1948

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.

NOT EMBALMED

Signed.....

J. C. Canada

Licensed Embalmer No. 4196

P. O. Address. Cassville, 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.