

No. 300
-10-47
-17-39
-1 2925

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

36932

State File No. _____

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. **4563**

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Lukes Children Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Kurt Douglas Walker
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 7 1948
(Month) (Day) (Year)

8. AGE: Years 00 Months 00 Days 1
If less than one day hr. min.

9. Birthplace Butler, Memorial Hospital
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name LeRoy Walker
13. Birthplace Butler, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Dorette Borland

15. Birthplace Bates Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant LeRoy Walker
(b) Address Butler, Missouri

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov 9, 1948
(Month) (Day) (Year)
(c) Place: burial or cremation Oakhill Cemetery Butler

18. (a) Signature of funeral director Culver-Underwood
(b) Address Butler, Missouri

19. (a) 11-8-48 (Date received local registrar) **(b)** Thereldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Bates
 (c) City or town Butler
(If outside city or town limits, write "RURAL")
 (d) Street No. None
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
 year 1948 hour 6 minute 55 A.M.

21. I hereby certify that I attended the deceased from November 7th
1948, to November 8th, 1948
 that I last saw him alive on Nov 7, 1948,
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
 Duration _____

Due to Surgical repair of omphalomesenteric hernia

Other conditions 1st
(Include pregnancy within 3 months of death)

Major findings:
 Of operations Omphalomesenteric hernia
 Of autopsy same as above

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? no

While at work? _____ (Specify type of place)
 (c) Means of injury _____
23. Signature Harry C. Gilkey (M. D. or D.O.)
 Address St. Lukes Hosp. K. C. Mo. Date signed 11/8/48

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

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.....

P. O. Address.....

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.

- (City, town, or county) (State or foreign country)
10. Usual occupation.....
11. Industry or business.....
- MOTHER FATHER {
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:.....
(Burial, cremation, or removal) (Month) (Day) (Year)
- (c) Place: burial or cremation.....
18. (a) Signature of funeral director.....
(b) Address.....
19. (a) (b)
(Date received local registrar) (Registrar's signature)

Other conditions *2000 original record*
(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.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

John D Underwood

Licensed Embalmer No.

3585

P. O. Address

Butler 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.