

FILED APR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12752

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1429

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | |
| c. LENGTH OF STAY (In this place) 3 YRS. | | d. STREET ADDRESS (If rural, give location) 100 S. Chelsea | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Residence, 100 S. Chelsea | | | |

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|---|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Russell c. (Last) Walker | | | 4. DATE OF DEATH (Month) (Day) (Year) Mar. 27, 1949 | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | |
| 8. DATE OF BIRTH Apr. 1, 1906 | | 9. AGE (In years last birthday) 42 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman | |
| 11. BIRTHPLACE (State or foreign country) Davis County, Mo. | | 12. CITIZEN OF WHAT COUNTRY? American | | 10b. KIND OF BUSINESS OR INDUSTRY Howard Needles Tamon Bergendorf | |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME Ira Ernest Walker | | 13b. MOTHER'S MAIDEN NAME Sarah A. Kissinger | | 14. NAME OF HUSBAND OR WIFE Carrie M. Walker | |
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|--|--|---|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 91 10 1395 | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Carrie M. Walker, Kansas City, Mo. | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Failure | | | | INTERVAL BETWEEN ONSET AND DEATH |
| | | ANTECEDENT CAUSES Bronchial Asthma | | | | |
| | | DUE TO (b) 2111 X | | | | |
| | | DUE TO (c) | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | |

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|------------------------|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Deputy Coroner | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|--|--|--|--|--|

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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
|--|--|--|--|---|--|

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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:15A m.**, from the causes and on the date stated above.

| | | | | | |
|-----------------------------------|--|------------------------------|--|-------------------------------|--|
| 23a. SIGNATURE A.E. Upsher | | (Deponent title) M.D. | | 23b. ADDRESS 2800 Main | |
|-----------------------------------|--|------------------------------|--|-------------------------------|--|

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|--|--|--------------------------|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 3/30/49 | | 24c. NAME OF CEMETERY OR CREMATORY Highland | |
| | | | | 24d. LOCATION (City, town, or county) (State) Hamilton, Mo. | |

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|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. 3-29-49 | | REGISTRAR'S SIGNATURE Sheraldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE Geo. C. Carson | |
| | | | | ADDRESS Independence, Mo. | |

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed John Parley

Signed _____
Student Embalmer

Licensed Embalmer No. 4308

P. O. Address Independence, 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.