

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25444**

FILED JUL 21 1952

BIRTH NO. _____ REG. DIST. NO. **299** PRIMARY REG. DIST. NO. **6028** Registrar's No. **15**

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

1. PLACE OF DEATH a. COUNTY Reynolds 0900		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Reynolds c. CITY (If outside corporate limits, write RURAL and give township) 1900	
b. CITY (If outside corporate limits, write RURAL and give township) Rural, Lesterville		c. CITY (If outside corporate limits, write RURAL and give township) Rural, Lesterville	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 9 mi. NW of Lesterville	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 9 miles NW of Lesterville			

3. NAME OF DECEASED (Type or Print)	a. (First) FANNIE	b. (Middle) BELLE	c. (Last) WALKER	4. DATE OF DEATH (Month) (Day) (Year) July 14 1952
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5. SEX fem /	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH May 24 1892	9. AGE (In years last birthday) 60	# UNDER 1 YEAR (Months) 1	# UNDER 24 HRS. (Hours) 20
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Reynolds Co. Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Francis Light	13b. MOTHER'S MAIDEN NAME Sarah Hasty	14. NAME OF HUSBAND OR WIFE George E. Walker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Goldie Stricklin, Ironton Mo.	ADDRESS Ironton Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs - several weeks years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Septicemic conditions over entire body basing DUE TO (c) toxemia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Complete ankylosis of several joints			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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., in or about 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?
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22. I hereby certify that I attended the deceased from **Jan. 10, 1948**, to **July 14, 1952**, that I last saw the deceased alive on **July 13, 1952**, and that death occurred at **6:55A m.**, from the causes and on the date stated above.

23a. SIGNATURE E. M. Fitzpatrick M.D. (Degree or title)	23b. ADDRESS Lesterville Mo.	23c. DATE SIGNED 7/18/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-16-52	24c. NAME OF CEMETERY OR CREMATORY Walker Branch Cem.	24d. LOCATION (City, town, or county) (State) Lesterville Mo.
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DATE REC'D BY LOCAL REG. 7/18/52	REGISTRAR'S SIGNATURE E. M. Fitzpatrick	25. FUNERAL DIRECTOR'S SIGNATURE White Funeral Home, Ironton Mo.	ADDRESS Ironton Mo.
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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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Russell White*

Licensed Embalmer No. *3012*

P. O. Address *Sanitarium*

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.