

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 27 1960

=60-022013

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 130

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CAPE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		c. CITY OR TOWN <u>CAPE GIRARDEAU</u>	
Length of stay in 1b <u>-</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO. DELTA COM. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>1610 S. SPRIGGS ST.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MILTON ALEXANDER WALKER</u>			4. DATE OF DEATH Month Day Year <u>5 - 14 - 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1938</u>	9. AGE (last birthday) <u>22</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMON LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>BLITHEVILLE, ARK.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>RAYMOND WALKER</u>		13b. MOTHER'S MAIDEN NAME <u>OLA MAE WARD</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>490-40-0980</u>		17. INFORMANT <u>MALINDA HAYNES, CAPE GIRARDEAU</u>	
				Address <u>610 HOLLY ST.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <u>Bun Shot Wound LEFT Side</u> <u>Below LOWER R.I.V.</u> <u>12 GAGE SHOT GUN.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>SCUFFLING OVER GUN</u>
20c. TIME OF INJURY Hour: <u>9:30 p.m.</u> Month, Day, Year: <u>5-14-60</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Sun set Add. Sikeston</u>	20f. CITY, TOWN, OR LOCATION <u>Sikeston</u>	COUNTY <u>Scott</u>	STATE <u>Mo.</u>
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21. I attended the deceased from FIRST CALL AFTER DEATH to last saw her alive on 9:20 p on the date stated above, and to the best of my knowledge, from the causes stated.
Death occurred at _____

22a. SIGNATURE (Degree or title) <u>Lloyd Poe Carone</u>		22b. ADDRESS <u>Sikeston Mo</u>		22c. DATE SIGNED <u>5/10/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>	23b. DATE <u>5-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIR MOUNT</u>	23d. LOCATION (City, town, or county) (State) <u>CAPE GIRARDEAU, MO.</u>	

24. FUNERAL DIRECTOR <u>ALVIN DOTSON, SIKESTON, Mo.</u>	ADDRESS <u>5-17-60</u>	25. DATE RECD. BY LOCAL REG. <u>5-17-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ella Hunter</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Wm. J. Marshall*

Licensed Embalmer No. 460

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.