MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11212

V. S. No. 2.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very i...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT ...

MARGIN RESERVED FOR BINDING

PLACE OF DEATH.

County Ray — Registration District No. 740 — File No.

Township Cooks Grove — Primary Registration District No. 6975 — Registered No. 10

City Melton (No. ... St. ... Ward)

FULL NAME Nancy Jane Walker

(a) Residence. No. ... St. ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
...ale	White	Widowed

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF J. S. Walker

DATE OF BIRTH (MONTH, DAY AND YEAR) January 27 - 1841

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	90	1	12	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) ...
(STATE OR COUNTRY) Missouri

NAME OF FATHER Pike Hall

BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY) Kentucky

MAIDEN NAME OF MOTHER Mary Dunsay

BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY) Missouri

INFORMANT Nancy Hall
(Address) Harding Mo

FILED Apr-10 1931 Jno W. Knipschild REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 11 1931

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1931, to March 11, 1931, that I last saw h...r alive on March 6, 1931, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11 D
132 D

(duration) ... yrs. ... mos. 7 ds

CONTRIBUTORY (SECONDARY) Uremic Poison

(duration) ... yrs. ... mos. 3 ds

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ...

DID AN OPERATION PRECEDE DEATH? No. DATE OF ...

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Marion Hesson, M. D

, 19 (Address) Harding, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Wall Cemetery	Mar-14 1931
20. UNDERTAKER	ADDRESS
Jno W. Knipschild	Harding Mo

...AL, or ...

...BURIAL ... 19

...RESS ...

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

.TH

..... Registration District No..... File No.....

..... Primary Registration District No..... Registered No. .....

..... (No..... ..... St. .....W

.....

No..... St., ...Ward. .....
lace of abode) (If nonresident give city or town and State)
ity or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

L AND STATISTICAL PARTICULARS

COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

ED, OR DIVORCED

IONTH, DAY AND YEAR)

MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

DECEASED

n, or
ek.....

al industry,
ment in
employer).....

r

IR TOWN).....

HER

F FATHER (CITY OR TOWN).....
NTRY)

OF MOTHER

F MOTHER (CITY OR TOWN).....
ITRY)

.....

.....

....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.

I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....,
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICI HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BU
20. UNDERTAKER	ADDRESS