

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

16268

**1. PLACE OF DEATH**County St. LouisTownship CARONDELETCity Jefferson Barracks man. U.S. Veterans Hospital, Jefferson Brks, Mo.Registration District No. 1123Primary Registration District No. 6248 B

File No. \_\_\_\_\_

Registered No. 193

Ward \_\_\_\_\_

**2. FULL NAME** George Walker(a) Residence, No. Helena, Mont. St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred un yrs. kn mos. own ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS****3. SEX**Male.**4. COLOR OR RACE**White.**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**Single.**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** \_\_\_\_\_**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb. 14, 1895**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

3233**8. OCCUPATION OF DECEASED**(a) Trade, profession, or particular kind of work Cook(b) General nature of industry, business, or establishment in which employed (or employer) Cook.(c) Name of employer Mr Wilson.**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Fort Worth, Texas.**10. NAME OF FATHER** Tom Walker**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Unknown.**12. MAIDEN NAME OF MOTHER** Helen Wright**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Unknown. Kansas.**14. INFORMANT** E. T. Gallagher  
B. T. Gallagher Medical Officer  
(Address) U.S. Veterans Hospital, Jefferson**15. FILED** May 18 1927  
L. C. Obrock  
REGISTRAR**MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)** May 17, 1927

17.

I HEREBY CERTIFY, That I attended deceased from November 9, 1926, 19\_\_\_\_, to May 17, 1927, 19\_\_\_\_, that I last saw h. im alive on May 17, 1927, 19\_\_\_\_, and that death occurred, on the date stated above, at 7:02 PM, \_\_\_\_\_ m.**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**Chronic Myocarditis.928  
936  
938  
900  
Sub-acute Bacterial Endocarditis;  
CONTRIBUTORY (SECONDARY) Mitral and Aortic Insufficiency.  
(duration) un yrs. kn mos. own ds.**18. WHERE WAS DISEASE CONTRACTED**IF NOT AT PLACE OF DEATH: UnknownDID AN OPERATION PRECEDE DEATH? Yes. DATE OF 12-21-26; 2-10-27  
3-24-27WAS THERE AN AUTOPSY? No.WHAT TEST CONFIRMED DIAGNOSIS? Physical & Laboratory findings.(Signed) H. W. Barker Chief Medical Officer USVH  
Medical Officer In Charge.

\*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. (See reverse side for additional space.)

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL****DATE OF BURIAL**National Gym Bldg May 17 1927**20. UNDERTAKER****ADDRESS**Wagon street & Co 781 4th Bldg  
also

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

WRITE FULL NAME OF DECEASED IN PLAIN TERMS IN SPACES PROVIDED

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Wife, Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: George Walker

Who died at: St. Louis Co, on May 17, 1927

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Chronic Myocarditis

~~Plastic operation of the face, and its subsequent wound.~~

Contributory: Subacute Bacterial Endocarditis, Mitral & Aortic Insufficiency

Where was disease contracted? \_\_\_\_\_

Did operation precede death? yes, Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

RECORD

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FILE

900

16268

Dr. L. C. Obrock,  
779 LeMay Ferry Road,  
St. Louis, Mo.

Dear Sir:-

Receipt is acknowledged of your Form No. 2, relative to the above named former patient of this hospital. It is regretted that this Form cannot be signed by any member of the staff because the Form as written is inaccurate and is not in accordance with the death certificate as returned from this hospital. It is also regretted that it is not possible to inform you where the disease to which his death was due was contracted, namely, Chronic Myocarditis, as this is unknown.

With reference to the appended slip requesting the cause for the relief for which the operation was performed, you are advised that when at this hospital, this patient underwent three operations under the direction of Dr. V.P. Blair, for the removal of a scar which was the result of a gun shot wound, which the patient's history indicates occurred about November 2, 1918. These operations involved the skin only, were performed under local anesthesia, healed within five days with no suppuration, and could not possibly have been in any way contributory to his death.

You are further advised that both the valvular heart disease and the myocarditis existed prior to his entrance to this hospital as shown by records in file.

By direction:

  
NATHAN BARLOW, M.D.  
Clinical Director.

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