DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31057

REG'D OCT 1 1 1939

Registration District No. 791

Primary Registration District No.

Registrar's No. 8120

1. PLACE OF DEATH: 1003

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 9/9/39 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 11

(d) Street No. 4236 Fairfax (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 426 Dorothy Mae (O'Day) WALKER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race C

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 30, 1916 (Month) (Day) (Year)

8. AGE: Years 22 Months 11 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) Louisiana (State or foreign country)

10. Usual occupation nil

11. Industry or business

FATHER
12. Name Robert Walker
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jessie Crawder Reynolds
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jessie Reynold
(b) Address St Charles Uno

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-21-39 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Mary Wade
(b) Address 4232 Finney Ave

19. (a) SEP 21 1939 (Date received local registrar) (b) J. Bullock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1939 hour 3 minute 50 a M.

21. I hereby certify that I attended the deceased from 9/9/39, 19, to 9/19/39, 19;
that I last saw her alive on 9/19/39, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary hemorrhage	
Pulmonary tuberculosis	more than 2 years
Due to --	
Due to --	
Other conditions -- (Include pregnancy within 3 months of death)	
Major findings: Of operations --	
Of autopsy --	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature M. Walker (M. D. or other)
Address 2601 N Whittier Date signed 9/20/39

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 6-17-39 I X19511

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.