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X23159

MAR 25 1941

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St Louis**

(c) Name of hospital or institution: **Homer G Phillips**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 days**

In this community **16 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Nellie Walker**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **col**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Walter Walker** 6. (c) Age of husband or wife if alive **6** years

7. Birth date of deceased **Sept 19 1861**

8. AGE: Years **79** Months **4** Days **21** If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business **Domestic**

12. Name **unknown unknown**

13. Birthplace **unknown 9 unknown** (City, town, or county) (State or foreign country)

14. Maiden name **unknown unknown**

15. Birthplace **unknown 9 unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Viola Walker**

(b) Address **1904 O'Fallon st.**

17. (a) _____ (b) Date thereof **2 15 41** (Month) (Day) (Year)

(c) Place: burial or cremation **Washington PK.**

18. (a) Signature of funeral director **A. E. Walter**

(b) Address **2707 Stoddard St**

19. (a) **FEB 15 1941** (Date received local registrar) (b) **J. H. M. Decker** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St Louis** (If outside city or town limits, write "RURAL") **1721**

(d) Street No. **1904 a O'Fallon** (If rural, give location) **F**

(e) If foreign born, how long in U. S. A.? **0** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **10** year **1941** hour **2:30** minute **A** M.

21. I hereby certify that I attended the deceased from **February 2**, 19**41**, to **February 10**, 19**41**, that I last saw her alive on **February 10**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease & Decom-pensation**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work _____ (Specify type of place)

(e) Means of injury **0**

23. Signature **Edith A. Decker** (M. D. or other)

Address **2601 N Whittier** Date signed _____

Duration **10-12mos**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

William C. McDowell....., Registered Apprentice No.....
working under my personal supervision.

Signed

William C. McDowell

Licensed Embalmer No.....

2117

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, fact should be so stated above.