

FILED MAR 8 1946  
Registration District No. *JW*

Primary Registration District No. *6076*

State File No. ....

Registrar's No. *35372*

1. PLACE OF DEATH:

(a) County *ST. LOUIS*  
(b) City or town *MANCHESTER*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
*PINE CREST HOMES 4*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *1/28/43 to 3/1/46*  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *St. Louis*  
(c) City or town *St. Louis*  
(If outside city or town limits, write "RURAL")  
(d) Street No. *4333 West Clayton*  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

*CHARLES WALKER*

3. (b) If veteran, name war *None* 3. (c) Social Security No. ....

4. Sex *MALE* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *1*  
6. (b) Name of husband or wife *unknown* 6. (c) Age of husband or wife if alive *24* years  
7. Birth date of deceased *FEBRUARY 24 1875*  
(Month) (Day) (Year)

8. AGE: Years *71* Months *-* Days *7* If less than one day hr. min.

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

10. Usual occupation *Unemployed*

11. Industry or business

MOTHER FATHER { 12. Name *unknown Geo. D. Walker*  
13. Birthplace *Unknown N.C.* (City, town, or county) (State or foreign country)  
14. Maiden name *Richette*  
15. Birthplace *Unknown Va.* (City, town, or county) (State or foreign country)

16. (a) Informant *Mrs Raymond H. Alewel*

(b) Address *1239 McLaren Ave*

17. (a) *Burial* (b) Date thereof *3/4/46*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Bethany Cemetery*

18. (a) Signature of funeral director *Math Hermann & Son*

(b) Address *2161 East Fair Ave*

19. (a) *3-4-46* (b) *E. M. Sarantak*  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* Day *11* Year *1946* hour *7* minute *45 A.M.*

21. I hereby certify that I attended the deceased from *7:15* 1946 to *March 1* 1946

that I last saw him alive on *Feb 27* 1946 and that death occurred on the date and hour stated above.

Immediate cause of death *chronic myocarditis* Duration

Due to *granulosis arteriosclerosis*

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature *A. J. Merkle M.P.* (M. D. or other)

Address *3507 Potomac* Date signed *3-1-46*

MAR 22 1946

**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 *William G. Buchhorn*

Licensed Embalmer No. *2110*

P. O. Address. *St. Louis, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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

Registration District No. 317

Primary Registration District No. 6026

Registrar's No. 537

**1. PLACE OF DEATH:**  
 (a) County St Louis  
 (b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Charles Walker  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Feb 2 (Month) 1946 (Day) \_\_\_\_\_ (Year)

8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_  
(If less than one Day)  
 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation unemployed

11. Industry or business \_\_\_\_\_  
 { 12. Name \_\_\_\_\_  
 { 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name \_\_\_\_\_  
 { 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month \_\_\_\_\_  
 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Includes 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)  
 (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3880

10827