

FILED MAY 6 1946
Registration District No. 319

Primary Registration District No. 6076

State File No.

Registrar's No. 936

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Robert Koch
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 237
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County - 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3035 Lawton 9
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT
FULL NAME

Lloyd Roland Walls

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

4. Sex mo 5. Color or race n 6. (a) Single, widowed, married, divorced m!

6. (b) Name of husband or wife Courne Walls 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 7 20
(Month) (Day) (Year)

8. AGE: Years 25 Months 4 Days 15 If less than one day hr. _____ min. _____

9. Birthplace St. Louis mo
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER { 12. Name Era Walls

13. Birthplace Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Eloise Griffin

15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Koch Hospital, Koch, mo

17. (a) Burial (b) Date thereof 4/23/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director J. A. Green
(b) Address 2915 Franklin Ave

19. (a) 4-27-46 (b) E. M. Bennett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 22
year 46 hour 1 minute 10 P. M.

21. I hereby certify that I attended the deceased from 8 to 28, 1945 to 4-22-45, 1945
that I last saw him alive on 4-22-45
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis 14 mths
Due to 13 1/2

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 fall

23. Signature Bernard Friedman (M. D. or other) MD

Address Koch Hospital, Koch, mo Date signed 4/23/46

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

13342

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OCT 11 1956

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

G. A. Green

Licensed Embalmer No. 2963

P. O. Address 2910 Franklin

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.