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DOM-5-43
ev. 5-17-39

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19019

FILED MAY 18 1946

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 4098

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY INFIRMARY HOSPITAL.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5/3/46 to 5/4/46
(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")
(d) Street No. 2500a N TAYLOR
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANDREW WALTERS

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

4. Sex MALE 2, 5. Color or race COLORED 6. (a) Single, widowed, married, divorced SEPARATED

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

7. Birth date of deceased JAN. 25, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 3 9 _____ hr. _____ min.

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

10. Usual occupation NIL

11. Industry or business _____

12. Name RAY WALTERS

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

14. Maiden name _____

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

16. (a) Informant CITY INFIRMARY RECORDS

(b) Address 5800 ARSENAL ST.

17. (a) Burial (b) Date thereof 5/9/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 107 Finney Ave.

19. (a) MAY 8 1946 (b) J. F. Broadach
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY, day 4,
year 1946 hour 11 minute 45 AM

21. I hereby certify that I attended the deceased from 5/3
1946, 19 , to 5/4, 1946
that I last saw h. im alive on 5/4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Regeneration
Due to arteriosclerosis
generalized

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

Major findings:
Of operations _____
Of autopsy _____

Duration

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 Julius M. Shier (M. D. or other) _____
Address 5800 Arsenal Date signed 5/4/46

(Licensed Embalmer's Statement on Reverse Side)

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

17897

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.....

Thomas J. Gates

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

working under my personal supervision.

Signed.....

Thomas J. Gates

Licensed Embalmer No..... 4259

P. O. Address..... 4107 Finney Ave.

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.