

No. 309
-10-47
5-17-39
I 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28486
Registrar's No. 1940

FILED SEP 7 1948
Registration District No. 17

Primary Registration District No. 3064

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

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

3. (a) PRINT FULL NAME Elizabeth Olive Walker.
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female | Color or race White
5. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Dr. John G. Walker.
6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased July 17, 1861.
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 0
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife.

11. Industry or business _____

12. Name Joseph Turner.

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

14. Maiden name Mary Waits.

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

16. (a) Informant Mrs. Paul Vineyard.

(b) Address 7477 Delmar Boulvard.

17. (a) Burial (b) Date thereof 8-20-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellevue Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) 8-19-48 (b) Cecil A. Z. Sharp, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL")
(d) Street No. 315 Church Street.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 17th.
year 1948 hour 11.45 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from Aug 16 - 1948 to Aug 17, 1948
that I last saw her alive on Aug 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Atrophic Myocarditis
Duration _____

Due to Arterio Sclerosis.

Due to Senile changes - 93

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 3

23. Signature Paul Vineyard, M.D. (M. D. or other) _____

Address 3781 Olive St St Louis Mo Date signed 8-18-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Clement McNeary
Licensed Embalmer No. 3732
P. O. Address St. Louis

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.