

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003

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: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 hours.
Previously under treatment of LMD (Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME Becker, Walter Cooley

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eleanor Becker 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dont Know 1883
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Sales Manager Brown Shoe Co.

11. Industry or business _____

12. Name Frederick BECKER

13. Birthplace Dont Know 6
(City, town, or county) (State or foreign country)

14. Maiden name CFARA or COOLEY (State or foreign country)

15. Birthplace Dont Know 11
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eleanor Becker

(b) Address 2932 A Hebert St.

17. (a) Removal (b) Date thereof 12-13-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dubuque Iowa

18. (a) Signature of funeral director Arthur J Donnelly

(b) Address 3840 Lindell Blvd

19. (a) DEC 17 1948 (b) J. B. Beaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2932 A Hebert St.
10 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17
year 1948 hour 12 minute 08 A.M.

21. I hereby certify that I attended the deceased from Dec.
17, 19 48, December 17, 19 48
that I last saw him alive on Dec. 17, 19 48,
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic coronary thrombosis
Duration 7 days

Due to Hypertension and arteriosclerosis
4 yrs.

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

Major findings: _____

Of operations _____
Of autopsy As above

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 FR Bradley (M. D. or other) _____
Address Barnes Hospital Date signed 12/17/48

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

W Van Matre

Licensed Embalmer No.

2825

P. O. Address

4340 Lafayette

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.