

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10791**
Registrar's No. **2124**

FILED MAR 19 1949

#15432

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____

23

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Madison		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			d. STREET ADDRESS (If rural, give location) 1411 (Rear) South Broadway		

3. NAME OF DECEASED (Type or Print)		a. (First) TOY	b. (Middle)	c. (Last) WALKER	4. DATE OF DEATH (Month) (Day) (Year) March 4, 1949		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 10, 1910	9. AGE (In years last birthday) 38	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Walker		13b. MOTHER'S MAIDEN NAME Sara E. Walker		14. NAME OF HUSBAND OR WIFE Donna Walker	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Nil	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Donna Walker-1411 South Broadway			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis of Lungs, Inj. Adv		INTERVAL BETWEEN ONSET AND DEATH 1941
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Possible Sarcoidosis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2/22/49** to **3/4/49**, 19**49**, that I last saw the deceased alive on **3/4/49**, 19**49**, and that death occurred at **10:55 PM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph E. Bledsoe M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 3/4/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Poplar Bluff, Missouri
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 7 1949 J. B. Slocater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe-4700 Washington
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Elmo R. Cadwell

Signed _____
Student Embalmer

Licensed Embalmer No. 4077

P. O. Address _____

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.