.S. No. 300
EV. 10-48

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

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39402

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9877

1. PLACE OF DEATH
a. COUNTY 1936 Wyoming
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis Missouri
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1936 Wyoming

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 1936 Wyoming

3. NAME OF DECEASED (Type or Print) a. (First) Robert Lee b. (Middle) Dewey c. (Last) Walker

4. DATE OF DEATH (Month) Nov. (Day) 15 (Year) 49

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8/22/1898
9. AGE (In years last birthday) 51 IF UNDER 1 YEAR Months 2 Days 23 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinesty
10b. KIND OF BUSINESS OR INDUSTRY Busch Selzer
11. BIRTHPLACE (State or foreign country) Paducah Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Lee Rupus Walker
13b. MOTHER'S MAIDEN NAME Nancy Bell Smith
14. NAME OF HUSBAND OR WIFE Leona Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leona Walker 1936 Wyoming

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; asthenia; etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Insufficiency c acute Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

ANTECEDENT CAUSES
Morbid 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.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1949, *to* 11-15, 1949, *that I last saw the deceased alive on* 11-12, 1949, *and that death occurred at* 5 15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Eugene H. Edele M.D.
23b. ADDRESS 4971 Chippewa St.
23c. DATE SIGNED 11-15-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/18/49
24c. NAME OF CEMETERY OR CREMATORY New St. Marcus
24d. LOCATION (City, town, or county) (State) St. Louis Missouri

DATE REC'D BY LOCAL REG. 16
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home ADDRESS 1926 Allen Ave

(Licensed Embalmer's Statement on Reverse Side)

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 me

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Dale A. Stratmann

Licensed Embalmer No. 4533

P. O. Address 1956 Allen

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.