

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6939**  
Registrar's No. **1782**

BIRTH FILED **MAR 11 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> |  | c. CITY OR TOWN <b>Clayton</b> <i>452</i>  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place) <b>1 day</b>  |  | e. STREET ADDRESS (If rural, give location) <b>7528 Parkdale</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Desloge Hospital</b>                              |  |  |   |

|  |                           |   |  |   |                             |  |
|--|---------------------------|---|--|---|-----------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>MYRA</b> b. (Middle) <b>SNODGRASS</b> c. (Last) <b>WALKER</b> |                           |   | 4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 24, 1954</b> |   |                             |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b> | 8. DATE OF BIRTH <b>Dec. 31, 1899</b>                      | 9. AGE (In years last birthday) <b>54</b>                                       | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>       |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>                      |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Little Rock, Arkansas</b> |                             | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME <b>Dr. William A. Snodgrass</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>Lelia P. Phillips</b> |  | 14. NAME OF HUSBAND OR WIFE <b>John Carroll Walker</b>                                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b> |  | 16. SOCIAL SECURITY NO. <b>none</b>                |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>James Walker, 4330 Oakcraft, Kirkwd.</b> |  |

|   |  |   |  |                                  |  |
|---|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  | MEDICAL CERTIFICATION                   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypoglycemia</b>  |  | DUE TO (b) <b>Hepatic insufficiency</b> |  | <b>1 day</b>                     |  |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                                       |  | DUE TO (c)                              |  | <b>6 months</b>                  |  |
| II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <b>Pneumothorax rt. lung punctured by needle</b> |  |   |  | <b>12 hrs.</b>                   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 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) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? <b>270X</b>   |  |

22. I hereby certify that I attended the deceased from **1947**, to **Feb. 24, 1954**, that I last saw the deceased alive on **Feb. 23, 1954**, and that death occurred at **6:30 a. m.**, from the causes and on the date stated above.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 23a. SIGNATURE (Degree or title) <b>Augustine Jones, M.D.</b> |  | 23b. ADDRESS <b>634 N. Grand, St. Louis</b>                                |  | 23c. DATE SIGNED <b>2-24-54</b>                               |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>    |  | 24b. DATE <b>2/25/54</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b> |  |
|   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |  |   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. <b>FEB 24 1954</b> |  | REGISTRAR'S SIGNATURE <b>Charles Smith M.D.</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Alexander &amp; Sons, Inc. 6175 Delmar</b> |  |
|---|--|---|--|--|--|

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

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..

Student.....  
Signature of Student Embalmer

Signed *Joseph E. McCallister*.....

Licensed Embalmer No. *2460*

P. O. Address *61 1/2 Dec*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.