

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36994

FILED OCT 26 1954

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8628**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis.</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>29</b>
c. LENGTH OF STAY (In this place) <b>5y, 5m, 2d.</b>		e. STREET ADDRESS (If rural, give location) <b>13 5800 Arsenal St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Charles</b>	b. (Middle) <b>James</b>	c. (Last) <b>Walters</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 20, 1954.</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 10, 1886</b>	9. AGE (In years last birthday) Months Days <b>67 10 10</b>	10. IF UNDER 1 YEAR Days <b>10</b>	10. IF UNDER 24 HRS. Hours Min. <b>10</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat cutter</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Indianapolis Ind.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Henry Walters.</b>	13b. MOTHER'S MAIDEN NAME <b>??</b>	14. NAME OF HUSBAND OR WIFE <b>Rose Walters.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1st World War</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Rose Walters</b>	ADDRESS <b>3429 S. Compton Ave.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION:		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Occlusion 5 months.</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 <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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4201</b>
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22. I hereby certify that I attended the deceased from April 18, 1946, to Sept. 20, 1954, that I last saw the deceased alive on Sept. 20, 1954, and that death occurred at 8:15p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>George M. Tanaka, M.D.</b>	23b. ADDRESS <b>5800 Arsenal St.</b>	23c. DATE SIGNED <b>SEP 21 1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>9/23/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 21 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Gebken Sons</b>	ADDRESS <b>2630 Gravois</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Robert F. Getke*.....

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.