

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25650**

FILED JUL 18 1956

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1576**

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY OR TOWN OLIVETTE MO.		c. CITY OR TOWN WEBSTER GROVES	
d. FULL NAME OF HOSPITAL OR INSTITUTION BONHOMME RESTORIUM		STREET ADDRESS # 305 BAKER AVE.	

3. NAME OF DECEASED (Type or Print) CHESTER CARPENTER WALKER	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH 6/27/1956
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4/26/1872	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 48 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEC. TREAS. RET.	10b. KIND OF BUSINESS OR INDUSTRY GROCERY CO	11. BIRTHPLACE (City and State or Foreign Country) McLEANSBORO ILL	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LEOMDAS WALKER	13b. MOTHER'S MAIDEN NAME AMY CARPENTER	14. NAME OF HUSBAND OR WIFE LEILA WALKER
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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) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mrs. C. Walker	ADDRESS 305 BAKER W. GROVES MO.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia		2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Prostate DUE TO (c) Hypertension Conditions contributing to the death but not related to the disease or condition causing death. adrenic sclerosis		2 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 177X	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?
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22. I hereby certify that I attended the deceased from **4/26, 1951**, to **June 7, 1956**, that I last saw the deceased alive on **6/24, 1956**, and that death occurred at **4 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE A. Victor Reese (Degree or title) MD	23b. ADDRESS 120 E Lockwood Webster Groves Mo	23c. DATE SIGNED 6/28/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 6/28/1956	24c. NAME OF CEMETERY OR CREMATORY OLD FELLOWS CEM.	24d. LOCATION (City, town, or county) (State) McLEANSBORO ILL.
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DATE REC'D BY LOCAL REG. 6-28-56	REGISTRAR'S SIGNATURE Hubert B. Lombard	25. FUNERAL DIRECTOR'S SIGNATURE PARKER ALDRICH FUNERAL INC.	ADDRESS Webster Groves Mo.
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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.

Student
Signature of Student Embalmer

Signed *Neville B. Frohwitter*

Licensed Embalmer No. *3696*

P. O. Address *154 Wood*

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.