Health, Welfare Public Service

300.
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 29274 7437

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes X No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 3528 Page Ave. — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits: Yes No
d. STREET ADDRESS (If outside, give location): 3528 Page Ave. — Reside on Farm: Yes No

3. NAME OF DECEASED (Type or print): First: John Middle: T Last: Walsh

4. DATE OF DEATH Month Day Year: 8-10-56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10-28-1883

9. AGE (In years last birthday): 72 — 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): Labor

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (City and state or country): St.Louis,Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Walsh

14. MOTHER'S MAIDEN NAME: Catherine Slattery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT Address: Mary Walsh 3528 Page Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA - Stomach — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-16-56, to 8-10-56 and last saw her/him alive on 8-9-56
Death occurred at 12:02a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): James Fuiks Do. D.

22b. ADDRESS: 6201 Lotus Ave

22c. DATE SIGNED: 8-11-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8-13-56

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St.Louis,Missouri

24. FUNERAL DIRECTOR: Jos.W.Clark F.H.Inc — ADDRESS: 1125 Hodiamont Ave.

25. DATE RECD. BY LOCAL REG.: AUG 11 1956

26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.R.

(Licensed Embalmer's Statement on Reverse Side)

55-1650

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John L Denne

Licensed Embalmer No. 41

P. O. Address St. Lou

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.