

FILED DEC 20 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44040

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10853**

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Overland</b> <b>400x</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		d. STREET ADDRESS <b>2829 Wheaton</b> (If outside, give location)	
3. NAME OF DECEASED (Type or print) <b>Floyd Russell Walden</b>		4. DATE OF DEATH <b>Nov. 26, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1895</b>
9. AGE (In years last birthday) <b>60</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>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Refrigerator Co. Green Co., Ark.</b>	
11. BIRTHPLACE (City and state or country) <b>Green Co., Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Coley E. Walden</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Russell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>431-42-3745</b>	
17. INFORMANT <b>Clara Walden, 2829 Wheaton</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>Coronary Arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) _____ 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ o. m. _____ p. m. _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>sev. years</b> to <b>time of death</b> and last saw her <b>11/20/56</b> <b>him</b> <b>11/20/56</b> Death occurred at <b>± 5:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Alfred H. Fishman, M.D.</b> (Degree or title)		22b. ADDRESS <b>2560A Woodman Rd</b>	
22c. DATE SIGNED <b>11/27/56</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-28-56</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Friendship</b>		23d. LOCATION (City, town, or county) (State) <b>Green Co., Ark.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 27 1956</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>			

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(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  
by me, ~~or by~~....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmer R. Fadel*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Lo*.....

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