

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 15 1957

44051

STATE FILE NUMBER
12079

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Vanderburgh	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Evansville <i>§1308</i>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Lakeview Dr.	
3. NAME OF DECEASED (Type or print) First Hyacinth Middle Madelain Last Walter		4. DATE OF DEATH Month 12 Day 30 Year 56	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 52
11. BIRTHPLACE (City and state or country) Mt. Vernon, Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence McNail		14. MOTHER'S MAIDEN NAME Amanda L. Hicks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edwards J. Walter, Lakeview Dr.		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) Respiratory paralysis DUE TO (b) Amytrophic lateral sclerosis DUE TO (c) 356.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 30 min. 4 months.
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 <input checked="" 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 _____ a. 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 12/18/56 to 12/30/56 and last saw her alive on 12/30/56 Death occurred at 3:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F.R. Bradley (Degree or title) MD		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 12/30/56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-29-56	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Evansville, Indiana	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,		25. DATE RECD. BY LOCAL REG. DEC 31 1956	
		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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.....
Stanley W. DeFord

Licensed Embalmer No.....
4

P. O. Address.....
St. Louis

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.