Health, & Welfare Public Service

S. 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 APR 22 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15413

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2422

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes # No ☐	c. CITY OR TOWN Florissant 400 / 0 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 09 DePaul Hosp. — Length of stay in 1b 9 days	d. STREET ADDRESS (If outside, give location) 27 570 St. Christina — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print)	First Charles	Middle Forrest	Last Walker
4. DATE OF DEATH	Month Mar.	Day 10,	Year 1957.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED # WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Oct. 19, 1949
9. AGE (In years last birthday) 7	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) Student	10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Charles Walker		14. MOTHER'S MAIDEN NAME Evelyn Porzel	
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. None	17. INFORMANT Address Evelyn Porzel, Florissant, Mo.	

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) BRONCHOPNEUMONIA

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) acute LEUKEMIA

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 204.3

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

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 NOVEMBER 15 to 3-19-57 and last saw her/him alive on 3-9-57

Death occurred at MARCH 10 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Nicholas C Kamakos MD	22b. ADDRESS 937 Airport Rd Ferguson	22c. DATE SIGNED 3-11-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-13-57	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery
23d. LOCATION (City, town, or county) (State) Florissant, Mo.		
24. FUNERAL DIRECTOR ADDRESS White Chapel, Ferguson, Mo.	25. DATE RECD. BY LOCAL REG. MAR 11 '57	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.J.B.

(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 emb

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Elena Province

Licensed Embalmer No. 340

P. O. Address Jennings

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.