

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19405**
Registrar's No. **4454**

FILED MAY 27 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. LENGTH OF STAY (in this place) 1 mo., 10 days | | d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp. | | e. STREET ADDRESS (If rural, give location) 2167 03400 S. Grand | |
| 3. NAME OF DECEASED (Type or Print) Minnie Walters | | 4. DATE OF DEATH (Month) (Day) (Year) 5 8 1957 | |
| 5. SEX female | | 6. COLOR OR RACE white | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow | | 8. DATE OF BIRTH March 7, 1870 | |
| 9. AGE (in years last birthday) 87 | | 10. IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and State or Foreign Country) Evansville, Ind. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |

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| 13a. FATHER'S NAME William Clark | 13b. MOTHER'S MAIDEN NAME unk. | 14. NAME OF HUSBAND OR WIFE Charles M. Walters |
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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 ADDRESS Charles M. Walters, Jr., 5878 Nottingham |
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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, asthenia, 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) Arteriosclerotic Heart Disease | | 1 1/2 mo. |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis | | 1 1/2 mo. |
| DUE TO (c) Generalized arteriosclerosis | | 1 1/2 mo. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 420.0 | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
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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) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **3-27-57**, 19**57**, to **5-8-57**, 19**57**, that I last saw the deceased alive on **5-8-57**, 19**57**, and that death occurred at **11:15 a.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) John W. Beckham, M.D. | 23b. ADDRESS 5800 Arsenal St. | 23c. DATE SIGNED 5/8/57 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | 24b. DATE 5-10-57 | 24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery |
| 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | |

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| DATE REC'D BY LOCAL REG. MAY 9 '57 | REGISTRAR'S SIGNATURE Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bred M. Williams, 4700 Washington Blvd. |
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(Licensed Embalmer's Statement on Reverse Side)

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

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 H. Dixon*
Licensed Embalmer No. *419*
P. O. Address *H. L.*

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.