

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033948

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 375

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		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. Francois Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>MAPLEWOOD</b> rd Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Hospt. #4</b>		Length of stay in 1b <b>9Y; 4M; 9das.</b>	d. STREET ADDRESS (If outside, give location) <b>3606 Oxford</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>WALSH</b> Last <b>WALSH</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>29,</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1884</b>		9. AGE (In years last birthday) <b>64</b> IF UNDER 1 YEAR: Months <b>3</b> Days <b>18</b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife; formerly nursing.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (City and state or country) <b>Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Dennis Casey</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Reed</b>	14. NAME OF HUSBAND OR WIFE <b>John P. Walsh</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Records, State Hospital No. 4, Farmington, Mo.</b>
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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>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis with acute colitis</b>	<b>Unknown.</b>
	DUE TO (c) <b>4221</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Manic Depressive Psychosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b></b>
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20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a.m. <b></b> p.m. <b></b>	20d. INJURY OCCURRED WHILE AT <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.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b>	COUNTY <b></b>	STATE <b></b>
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21. I attended the deceased from <b>Jan. 24, 1949</b> to <b>Sept. 29, 1958</b> and last saw her alive on <b>Sept. 29, 1958</b> Death occurred at <b>6:10 A. M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>	22c. DATE SIGNED <b>9-29-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 1, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>M. J. Croghan, 7146 Manchester, Maplewood, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct. 11, 1958</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

6961 2 JAN 2 1956

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 *C. H. Cozear* \_\_\_\_\_

Licensed Embalmer No. *4094*  
P. O. Address *Farmington*

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.