

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-030869

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4736 Sigel Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EUGENE Middle A. Last WALSH				4. DATE OF DEATH Month Aug. Day 18th. Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-21-1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oilier			10b. KIND OF BUSINESS OR INDUSTRY Water Dept.		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Walsh			13b. MOTHER'S MAIDEN NAME Julia Mc Sweeney			14. NAME OF HUSBAND OR WIFE Late Hazel Walsh		
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. 498-34-7902		17. INFORMANT Address Eugene E. Walsh-4736 Sigel Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial occlusion							INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardes Renal syndrome							1 mo	
DUE TO (c) Generalized arteriosclerosis							5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year						
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 1955 to 8-18-59 and last saw her/him alive on 8-17-59 Death occurred at 12:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) E. W. Withler M.D.				22b. ADDRESS 5600 S Compton		22c. DATE SIGNED 8-18-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 20, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) St. Louis,		23e. (State) Mo.		
24. FUNERAL DIRECTOR ADDRESS Kriegshauser-4228 S. Kingshighway				25. DATE RECD. BY LOCAL REG. AUG 18 '59		REGISTRAR'S SIGNATURE Karl Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. Storvick

Licensed Embalmer No. 4007

P. O. Address St. Louis,

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.