URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

211632 '59 046051 STATE FILE NUMBER

IENDED

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

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 24 days

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:

c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 4306 Olive St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Corinne Middle: Katie Last: Walsh

4. DATE OF DEATH: Month Day Year: 12-11-59

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 1/6/1878

9. AGE (last birthday): 81 — 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): Retired Private Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Shapleigh Hdwe. Co.

11. BIRTHPLACE (City and state or country): Decatur, Ill.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Alphonso Elder

13b. MOTHER'S MAIDEN NAME: Laura Blackburn

14. NAME OF HUSBAND OR WIFE: -- Frank Walsh

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: Mrs. Burt Elder, 2402 River Dr., Kirkwood, 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): Bilat. Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized Arteriosclerosis - 3 mos.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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 11-17-59, to 12-11-59 and last saw her/him alive on 12-11-59

Death occurred at 7:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.

22b. ADDRESS: 5800 Arsenal

22c. DATE SIGNED: 12/15/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: 12-15-59

23c. NAME OF CEMETERY OR CREMATORY: Valhalla Crematory

23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc. ADDRESS: 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: DEC 15 1959

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. MDR.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.