

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048386

FILED VS JAN 9 1961

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3613

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo</u>		Length of stay in 1b <u>63 days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1417 Franklin Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>-</u> Last <u>WALKER</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>60</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-05</u>		9. AGE (last birthday) <u>55</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>MISSISSIPPI</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Ernest Walker</u>				13b. MOTHER'S MAIDEN NAME <u>Marie Johnson</u>				14. NAME OF HUSBAND OR WIFE <u>Nil</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>???</u>		17. INFORMANT Address <u>Medical Records Koch Hospital</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA (Undifferentiated)</u> DUE TO (b) <u>Carcinoma... Site Unknown</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Traumatic Amputation of Right Lower</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <u>10-11-1960</u> to _____ and last saw ^{her} him alive on <u>12-13-60</u> Death occurred at <u>7:05 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Arthur H. Russell, M.D.</u>						22b. ADDRESS <u>Robert Koch Hospital</u>				22c. DATE SIGNED <u>12-13-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-16-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETARY St. Louis</u>				23d. LOCATION (City, town, or county) (State) <u>Mo.</u>					
24. FUNERAL DIRECTOR <u>McCLAIN</u>				ADDRESS <u>2812 CASS</u>		25. DATE RECD. BY LOCAL REG. <u>12-15-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 25 1961

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 Wallace R. Hill
5135 Latis
Licensed Embalmer No. 4936

P.O. Address _____

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.