

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

8877

-61-035080

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 13 1961

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>St Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. A. City Hosp II</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4245 Maryland</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Andrew</i> Middle Last <i>Walker</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>21</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 1910</i>	9. AGE (last birthday) <i>50</i>	IF UNDER 1 YEAR Months <i>10</i> Days <i>11</i>	IF UNDER 24 HR Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>ARKANSAS</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>JAMES WALKER</i>			13b. MOTHER'S MAIDEN NAME <i>ARLENE BROWN</i>		14. NAME OF HUSBAND OR WIFE <i>DECEASED</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Leroy Richardson</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage within the left</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Pleural cavity resulting from</i> DUE TO (c) <i>a ruptured aortic aneurysm</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>022x</i>					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 checked="" type="checkbox"/> NO <input 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 <i></i> a.m. <i></i> 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Joseph M. [Signature]</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9-21-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>26 Sept. 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oakdale Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>			
24. FUNERAL DIRECTOR <i>Reliable Funeral Sys. 1389 N. Union</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 25 1961</i>		26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>		

DATE AMENDED

STATEMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charence Craam

Licensed Embalmer No. 4755

P. O. Address 1389 Union

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.