

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017514

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1177 STATE FILE NUMBER

FILED APR 27 1962

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bellefontaine neighbors</u> Length of stay in job <u>5 years</u>		c. CITY OR TOWN <u>Bellefontaine neighbors</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10695 Bellefontaine Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis State School and Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Sherman</u> Last <u>Wall</u>	
4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1962</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</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>4-29-1941</u> 9. AGE (last birthday) <u>20</u> 4-29-61 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) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (City and state or country) <u>Van Lear Tennessee</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13a. FATHER'S NAME <u>Alpha Wall</u> 13b. MOTHER'S MAIDEN NAME <u>Killie Porter</u> 14. NAME OF HUSBAND OR WIFE	
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>None</u> 17. INFORMANT <u>Records of St Louis State School</u> Address <u>None</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>Cerebral Vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic brain syndrome associated with congenital lues</u> DUE TO (c)			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) <u>Mental deficiency</u>			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 <u>None</u> 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>January 1956</u> to <u>April 1962</u> and last saw her <u>4-14-1962</u> alive on <u>4-14-1962</u> . Death occurred at <u>4:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Adrian P. Murphy M.D.</u> (Degree or title)		22b. ADDRESS <u>10695 Bellefontaine Road</u>	22c. DATE SIGNED <u>4/16/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-18-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>4-16-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Washington
St. Louis, mo

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.