

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

7200

1. PLACE OF DEATH

County St. Louis Mo. Registration District No. 721 File No. 2287
 Township St. Louis No. Prime Registration District No. Lutheran Hosp. Registered No. 2287
 City St. Louis Mo. (N. Lutheran Hosp.) St. Ward

2. FULL NAME

Edward L. Walker
 (a) Residence No. 4249 Castleman St. Ward 7
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OF RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Annice C. Walker</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 1 - 1854</u>		
7. AGE <u>69</u>	YEARS <u>1</u>	MONTHS <u>27</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Watchman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Tobacco Co.</u> (c) Name of employer <u>Liggett & Myers</u>		If LESS than 1 day, hrs. or min.
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Mo.</u>		
PARENTS	10. NAME OF FATHER <u>John Walker</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Mo.</u>	
	12. MAIDEN NAME OF MOTHER <u>Anna Short</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>		
14. INFORMANT <u>C. W. Walker</u> (Address) <u>1478 & Clara Ave</u>		
15. FILED <u>MAR 3 1923</u> <u>Mar. B. Staroff</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28, 1923

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1923, to Feb 28 1923 that I last saw him alive on Feb 28 1923 and that death occurred, on the date stated above, at 4:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diagnosis of Leg. Amputation of Leg.

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage
Artery (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH,
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb 26
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. C. Green, M. D.
 , 19 (Address) 3833 Folsom

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calhoun Cem. DATE OF BURIAL Mar 3 1923

20. UNDERTAKER Wm. Imbruster Mnd Co. ADDRESS 434 Manchester

WRITE PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

1 PLACE OF DEATH

County

Township

or

Village

or

City St Louis (No.)DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of 791
1003

Registered No. 2287

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward L. Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

w

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (If true the word)

m

6 DATE OF BIRTH

....., 191....., to 191....., (Month) (Day) (Year)

7 AGE

..... yrs. mos. ds. OR

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

MAY 18 1923

19

Max L. Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 28 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to 191.....,

that I last saw h..... alive on 191.....,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Amputation of leg 202
None Traumatic
Information given over Phone by
Dr. W. G. Owen 5-18-23
(Duration) yrs. mos. ds.Contributory Div. of W. S.

(Duration) yrs. mos. ds.

(Signed), M. D.

....., 191..... (Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death ?

Former or usual residence

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SUPPLEMENTAL

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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