

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

REC'D AUG 17 1939

791
1003

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24358
Registrar's No. 6631

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since Apr. 12, 1939
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4128a Easton
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Oliver Walker 421

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 13, 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 3 12 _____ hr. _____ min.

9. Birthplace Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER
12. Name Robert Walker
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Rose Walker
15. Birthplace Louisiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Richard Summers

(b) Address 3113 R. Easton

17. (a) Burial (b) Date thereof July 29, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director (People's) Washington

(b) Address 3107 Franklin Ave

19. (a) JUL 28 1939 (b) J.F. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1939 hour 7 minute 40 p. M.

21. I hereby certify that I attended the deceased from April 12, 1939
_____, 19____, to July 25, 1939, 19____;
that I last saw him alive on July 25, 1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis 1 year
Duration

Due to _____

Due to _____

Other conditions Phimosi
(Includes pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury !

23. Signature M. W. [Signature] (M. D. or other)

Address 2601 N. Whittier Date signed 7/28/39

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, ~~and~~.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *Henry Goodin*.....

Licensed Embalmer No. *7050*.....

P. O. Address *4237 W L Abadie*.....

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 this body is not embalmed, above space should be left blank.