

MAY 15 1940

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution: Maple Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Verna Walker ⁴²⁶

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

4. Sex Female 5. Color Pol 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Calvin Walker 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Jan 29 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Factory Work

11. Industry or business _____

MOTHER FATHER { 12. Name Min Ross

18. Birthplace Mem Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Dora Henry

15. Birthplace Melvin Ala
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Margaret Walker

(b) Address 4461 Kennedy

17. (a) Burial (b) Date thereof 4/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director F. W. Allen

(b) Address 2915 Franklin Ave
APR 22 1940
(Date received local registrar) (b) J. B. Brecher
(Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4461 Kennedy
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1940 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-19-1940
to 4-18-40, 1940, to 4-18-40, 1940

that I last saw her alive on 4-18-40 11-20 P. M.
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute Dilatation of Heart

Due to _____

Due to Toxic adenoma of glands

Other conditions Improved gland
(Include pregnancy within 3 months of death)

Major findings: Thyroidectomy 9-4-13-1940

Of operations _____

Of autopsy _____ 66

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, town) (County) (State)

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

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

23. Signature J. B. Brecher (M. D. or other) _____

Address 822 E. Jefferson Date signed _____

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

J. A. Green

Licensed Embalmer No. *2963*

P. O. Address. *2915 Franklin*

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.