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13207

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 20 1944

1003

Registrar's No. 3473

Registration District No. 318

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:
St. Luke's Hospital 0
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Sangamon 999

(c) City or town Springfield
(If outside city or town limits, write "RURAL") NR

(d) Street No. 610 S. Illinois
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Walter Pickering, Jr.

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1944 hour 7:15 minute _____ P. _____ M. _____

4. Sex Male 0 5. Color or race White

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 17 1927
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 8
1944 to April 13 1944

that I last saw him alive on April 13 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>16</u>	<u>11</u>	<u>26</u>	hr. _____ min. _____
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Immediate cause of death _____
Tumor of Brain Malignant

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: Same

Of autopsy: Same

9. Birthplace: Springfield Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation: Student

11. Industry or business _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Walter Pickering, Sr.

13. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs. Cummings

(b) Address 767 Radcliffe

17. (a) Removal (b) Date thereof 4-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 14 1944 (b) J. F. Hagedorn
(Date received local registrar) (Registrar's signature)

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) (List means of injury)

23. Signature D. M. Cummins (M. D. or other) M.D.
Address 4952 Maryland Ave Date signed 4/14/44

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

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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 W. W. Wilkinson
Licensed Embalmer No. 35757

P. O. Address.....

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, fact should be so stated above.