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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15868**
Registrar's No. **1054**

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Florissant (rural)**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
RFD.#3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **5 Months**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Florissant (rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **RFD#3**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN C. WALKER**
3. (b) If veteran, name war **No.**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **7**
year **1944** hour **7** minute **45** A.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (c) Age of husband or wife if alive **-----** years
7. Birth date of deceased **June 7 1868**
(Month) (Day) (Year)

Immediate cause of death **Coronary occlusion; arteriosclerosis**
Duration _____

8. AGE: Years Months Days If less than one day
75 11 0 hr. min.

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

9. Birthplace **Fenton Mo.**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation **Retired Carpenter**

11. Industry or business **Building**

12. Name **Philip Walker**

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

14. Maiden name **Margaret Maxe**

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

16. (a) Informant **R. Walker**
(b) Address **Eureka, Mo.**

17. (a) **Burial** (b) Date thereof **May 9, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cem. Kirkwood, Mo.**

18. (a) Signature of funeral director **Geo. L. Shickel**
(b) Address **Pacific, Mo.**

19. (a) **MAY 8 - 1944** (b) **E. G. McQuarrie**
(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) (e) Means of injury **Ind**
23. Signature **J. W. ...** (M. D. or other) **Ind**
Address **St. Louis County Health Dept** Date signed **1944**

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

MOTHER FATHER

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.....

working under my personal supervision.

Registered Apprentice No.

Signed

Geo L Sheehy

Licensed Embalmer No. 3008

P. O. Address

Pacific 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 this body is not embalmed, fact should be so stated above.