S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 4 1947

Registration District No. 3063

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File 28
Registrar's No. 1607

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

1. PLACE OF DEATH:
(a) County: St. Louis County
(b) City or town: Clayton, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 25 min (Specify whether years, months or days)
In this community: 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis 96
(c) City or town: Ferguson Mo. (If outside city or town limits, write "RURAL")
(d) Street No.: 157 N. Elizabeth (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: John T Walsh
3. (b) If veteran, name war:
3. (c) Social Security No. 446-26-4449
4. Sex: M
5. Color or race: wh
6. (a) Single, widowed, married, divorced: ~~M~~ W
6. (b) Name of husband or wife: Lorraine Walls
6. (c) Age of husband or wife if alive: (div.) years
7. Birth date of deceased: 5 (Month) - 9 (Day) - 1899 (Year)

8. AGE: Years	Months	Days	If less than one day
48 49	2	18 17	hr. min.

9. Birthplace: St. Louis, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Shoe worker
11. Industry or business: Bauer Brothers
FATHER 12. Name: Thomas J Walsh
13. Birthplace: New York, N.Y. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Margaret Tolley
15. Birthplace: St. Louis, Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: Bro. Michael Walsh
(b) Address: 157 N. Elizabeth
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/30/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery
18. (a) Signature of funeral director: Sullivan Funeral Dir.
(b) Address: 2849 North Euclid Ave.
19. (a) 7-28-47 (Date received with registrar) (b) Cecil A. Shorp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 27th year: 1947 hour: 11 minute: 35 P.M.
21. I hereby certify that I attended the deceased from July 27, (11:10am) 1947 to July 27th, 1947; that I last saw him alive on July 27th, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Respiratory Failure.	12 hrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autops: Chronic Pulmonary Tuberculosis & Cavitation

PHYSICIAN
Underline the cause of 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? (Specify kind of place)
While at work: Means of injury:
23. Signature: Russell L. Gardner (M.D. or other)
Address: St. Louis County Hospital Date signed: 7/27/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

SEP 11 1949

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 Robert L Brinkman

Licensed Embalmer No. 3553

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.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1600

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis County

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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 (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John J. Walsh

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife

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

7. Birth date of deceased: May 9 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 7 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 7-28-47 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 27
year 1947 hour minute 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

5-26268