

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25377**
Registrar's No. **6859**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo/ b. COUNTY 000		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		17
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			d. STREET ADDRESS (If rural, give location) 5750 Holly Hills		
3. NAME OF DECEASED (Type or Print) a. (First) EDWARD		b. (Middle) E.	c. (Last) WALSH		4. DATE OF DEATH (Month) (Day) (Year) Aug. 5 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 25, 1887	9. AGE (In years less birthday) 62	IF UNDER 1 YEAR Months 5 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shaughnesy-Kniep	11. BIRTHPLACE (State or foreign country) Buffalo, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Emil Walsh		13b. MOTHER'S MAIDEN NAME Catherine Murphy		14. NAME OF HUSBAND OR WIFE Alice Walsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs Alice Walsh-5750 Holly Hills.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Hypernephroma ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION Hypernephroma.			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 52W		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 180X		
22. I hereby certify that I attended the deceased from 3rd Aug, 1949 , to 5 Aug, 1949 , that I last saw the deceased alive on 5 Aug, 1949 , and that death occurred at 8:00P m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Raymond [Signature]		23b. ADDRESS 5203 Chryseim		23c. DATE SIGNED 8-6-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/8/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
DATE REC'D BY LOCAL REG. AUG 7 1949	REGISTRAR'S SIGNATURE J.B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser-4228 S. Kingshighway Bl.		

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

OCT 20 1950

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.

Student Embalmer No.....

Signed Richard W. Storrsand

Signed.....
Student Embalmer

Licensed Embalmer No. 4007

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.