

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32301

State File No.

98258

7868

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) 7324 Alabama Ave.			
3. NAME OF DECEASED (Type or Print)		a. (First) William		b. (Middle) Walsh		c. (Last) _____	
4. DATE OF DEATH		(Month) Sept.		(Day) 9th,		(Year) 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH 11-24-1888	
9. AGE (In years last birthday) 60		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab. Maker				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis	
12. CITIZEN OF WHAT COUNTRY? _____							
13a. FATHER'S NAME Michael Walsh			13b. MOTHER'S MAIDEN NAME Nellie Williams			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. 499-01-4082		17. INFORMANT'S SIGNATURE OR NAME Mrs. Carrie Walsh ADDRESS 7322 Alabama			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Adhesive Pericarditis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Chronic Anemia of Unknown Origin!				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) Mo.			
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? Hit by			
22. I hereby certify that I attended the deceased from 8-26-49 , 19____, to 9-9-49 , 19____, that I last saw the deceased alive on 9-9-49 , 19____, and that death occurred at 4:55A m., from the causes and on the date stated above.							
22a. SIGNATURE Carroll Hendrickson M.D. (Degree or title) _____				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 9-9-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-12-49		24c. NAME OF CEMETERY OR CREMATORY Park Lawn		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. SEP 11 1949		REGISTRAR'S SIGNATURE J. B. Lester			25. FUNERAL DIRECTOR'S SIGNATURE Jos. P. Fendler Jr. ADDRESS 7128 Michigan		

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Clarence Pochow

Licensed Embalmer No. *3093*

P. O. Address *7128 Michigan*

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.