

FILED SEP 9 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28770

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7325</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE OF DECEASED LIVED. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		2059		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital #1</b>				d. STREET ADDRESS (If rural, give location) <b>6034 Etzel Ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b> b. (Middle) <b>G</b> c. (Last) <b>WALSH</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 27 1950</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 27 1900</b>		9. AGE (In years last birthday) <b>50</b> If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <b>Peter Walsh</b>		13b. MOTHER'S MAIDEN NAME <b>Isabelle Dumont</b>		14. NAME OF HUSBAND OR WIFE <b>Estelle Walsh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Estelle Walsh 6034 Etzel Ave.</b>				
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) <b>Arteriosclerotic Heart Disease</b> 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. <b>Emphysema of liver</b> <b>arteriosclerotic aortoma</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>  <b>2 yrs</b> <b>2 yrs</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
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) _____				
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? <b>Heart</b>				
22. I hereby certify that I attended the deceased from <b>8-26</b> , 19 <b>48</b> , to <b>8-27</b> , 19 <b>50</b> that I last saw the deceased alive on <b>8-23</b> , 19 <b>50</b> and that death occurred at <b>10:00 a. m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Chas. Foster, D. O.</b>				23b. ADDRESS <b>3500 N. Grand</b>		23c. DATE SIGNED <b>8-29-50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/30/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>		
DATE REC'D BY LOCAL REG. <b>AUG 29 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sullivan Funeral Dir. 2849 N. Euclid</b>				

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 *Gustav A. Eckert* \_\_\_\_\_

Licensed Embalmer No. *4329* \_\_\_\_\_

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.