

10.300
0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38890
State File No.
Registrar's No. **0903**

FILED FEB 11 1953

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) Saint Louis 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 1218 Blair St.	
3. NAME OF DECEASED (Type or Print) Thomas Walker		4. DATE OF DEATH (Month) (Day) (Year) Jan. 22, 1953	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 10, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	9. AGE (In years last birthday) 76 11. BIRTHPLACE (City and State or Foreign Country) Louisiana
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?	14. NAME OF HUSBAND OR WIFE Mattie Walker
17. INFORMANT'S SIGNATURE OR NAME John Henry Marshall		ADDRESS 1307 Biddle 3rd Fl.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES 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.			
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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR 4200	
22. I hereby certify that I attended the deceased from Jan 19 1953 to 21 Jan, 1953 , that I last saw the deceased and that death occurred at 5:30 P.M. from the cause and on the date stated above			
SIGNATURE, REMOVAL (Specify) Removal		23. FUNERAL DIRECTOR'S SIGNATURE W. E. B. Kame	
DATE REC'D BY LOCAL REG. JAN 26 1953		ADDRESS 1221 N. Grand Blvd.	
REGISTRAR'S SIGNATURE J. Carl Smith		ADDRESS 1221 N. Grand Blvd.	

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

(Licensed Embalmer's Statement on Reverse Side)

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

Lawrence Craven

Licensed Embalmer No. *4755*

P. O. Address *1221 N. Grand*

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.