

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8041

State File No. ....

FILED MAR 11 1953

BIRTH NO. 1 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1707

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis MO 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 11 4532 Bayfield Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Dorsey	b. (Middle) L.	c. (Last) Walker	4. DATE OF DEATH (Month) (Day) (Year) 2 12 53
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5. SEX male	6. COLOR OR RACE Cald	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 1, 1924	9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months 4	IF UNDER 1 HR. Days 11	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Mts.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Jackson, Tenn	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Thomas S. Walker	13b. MOTHER'S MAIDEN NAME Mallie Cole	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT'S SIGNATURE OR NAME Princess Walker	ADDRESS 4532 Bayfield
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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 (Medullary) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Softening of the Brain Decomposition		INTERNAL BETWEEN ONSET AND DEATH 4 hrs.
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ANTECEDENT CAUSES DUE TO (b) Craniotomy Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arnold-Chiari Syndrome
DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Arnold-Chiari Syndromes	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 7531
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22. I hereby certify that I attended the deceased from Feb. 6, 1953, to Feb. 12, 1953, that I last saw the deceased alive on Feb. 12, 1953, and that death occurred at 5:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE FR Bradley	(Degree or title) M. D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 2/12/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-17-53	24c. NAME OF CEMETERY OR CREMATORY Jackson Tenn	24d. LOCATION (City, town, or county) (State) Jackson, Tenn
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DATE REC'D BY LOCAL REG. FEB 13 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. L. Beal	ADDRESS 4303 Delmar
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(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300  
V. 10.48

**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 Leroy W. Barnister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Ave.

**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.