

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8047

State File No.

1979

FILED MAR 11 1953

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)	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis, Mo.		a. STATE Illinois b. COUNTY St. Clair	
c. LENGTH OF STAY (in this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) E. St. Louis 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 1707 Market Ave.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Alexander		b. (Middle) NMN	
c. (Last) Walton		2 16 53	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6/13/1884
9. AGE (in years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) Tennessee
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unavailable	
13b. MOTHER'S MAIDEN NAME Nancy Tigue		14. NAME OF HUSBAND OR WIFE Lula Walton	
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. 332-20-4401	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lula Walton 1707 Market Ave.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma - disseminated		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 checked="" 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. HOW DID INJURY OCCUR 2001	
21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from Feb 10, 1953, to Feb 16, 1953, that I last saw the deceased alive on Feb. 16, 1953, and that death occurred at 2:15Pm., from the causes and on the date stated above.	
23a. SIGNATURE FR Bradley (Degree or title)		23b. ADDRESS M. D. BARNES HOSPITAL	
23c. DATE SIGNED 2/18/53		24. LOCATION (City, town, or county) (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/22/53	
24c. NAME OF CEMETERY OR CREMATORY Booker Washington		24d. LOCATION (City, town, or county) (State) Centreville Twp. Ill	
DATE REC'D BY LOCAL REG. FEB 20 1953		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE R. M. Co. Green		25. FUNERAL DIRECTOR'S ADDRESS 3517 Laclede	

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

Melvin E. Green

Licensed Embalmer No. *4428*

P. O. Address *St. Louis, Mo.*

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.