

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

16335

State File No.

Registrar's No. **3936**

FILED MAY 14 1953

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) St. Louis d. STREET ADDRESS (If rural, give location) 902 N Taylor	
3. NAME OF DECEASED a. (First) Ida b. (Middle) _____ c. (Last) Walker		4. DATE OF DEATH (Month) (Day) (Year) April 10 1953	
5. SEX Female 6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April 1, 1903 9. AGE (In years last birthday) 50 IF UNDER 1 YEAR: Months _____ Days 9 IF UNDER 24 HRS: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) Sardis		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Geason Fairley		13b. MOTHER'S MAIDEN NAME Rachel	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach with Metastasis to Liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	INTERVAL BETWEEN ONSET AND DEATH _____
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X

22. I hereby certify that I attended the deceased from 4-8 1953, to 4-10 1953, that I last saw the deceased alive on 4-10 1953, and that death occurred at 1:30p m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Edueg Brooks M.D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 4-11-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-16-53	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. APR 15 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE M. E. Keane		ADDRESS 1221 N. Grand

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 _____

Guyton Swann

Licensed Embalmer No. *4580*

P. O. Address *1221st Grand Bl*

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.