

FILED JUL 31 1953

STANDARD CERTIFICATE OF DEATH

State File No. 26995
6287

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) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4380 W. PINE</u>		d. STREET ADDRESS (If rural, give location) <u>4380 W. PINE</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>LAWRENCE</u> b. (Middle) <u>O.</u> c. (Last) <u>WALKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 23 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 22 - 1900</u>
9. AGE (In years last birthday) <u>52</u>		10. MONTHS <u>52</u>	11. DAYS <u>52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1211 MO. BARBER SUPPLY</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>TENN</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>HARRY WALKER</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY OWEN</u>		14. NAME OF HUSBAND OR WIFE <u>ARLYNN SAUNDERS WALKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY # <u>497-10-0483</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Arlynn Saunders Walker</u>		ADDRESS <u>4380 W. PINE</u>	
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) <u>Chronic Myocarditis</u> <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiac</u> <u>Vascular Disease</u> DUE TO (c) <u>Anginal Syndrome</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Parkinson Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mon</u> <u>3 days</u> <u>18 mon</u> <u>18 mon</u> <u>18 mon</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		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 (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>12-28-1951</u> , to <u>6-23-1953</u> , that I last saw the deceased alive on <u>6-23-1953</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. Remondok M.D.</u>		23b. ADDRESS <u>4390 West Pine Bl.</u>	
23c. DATE SIGNED <u>6-23-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>JUNE 25 1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		24d. LOCATION (City, town, or county) (State) <u>Quincy Ill</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Smith M.D.</u>		ADDRESS <u>Cullen Kelly 4386 Lindock</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JUN 23 1953</u>			

H.T. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACKINK—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 _____

J. Allen Davis
Licensed Embalmer No. *4054*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.