

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 19 1954

State File No. 12225  
Registrar's No. 12225

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY <b>D</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>12 Days</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>8 8629 Drury Lane</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Edward</b> b. (Middle) <b>J.</b> c. (Last) <b>Walsh</b>			4. DATE OF DEATH <b>Dec 26 1953</b> (Month) (Day) (Year)		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 24, 1905</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Treasurer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Associated Grocers</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>David Walsh</b>		13b. MOTHER'S MAIDEN NAME <b>Bridget Shea</b>		14. NAME OF HUSBAND OR WIFE <b>Genevieve Walsh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>488-10-1663</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Genevieve Walsh 8629 Drury Lane.</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis.</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
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. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4201</b>			
22. I hereby certify that I attended the deceased from <b>Dec. 15, 1953</b> , to <b>Dec. 26, 1953</b> , that I last saw the deceased alive on <b>Dec. 25, 1953</b> , and that death occurred at <b>9:20 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>D. B. Glavan</b>		(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>539 N. Grand Bl. St. Louis</b>		23c. DATE SIGNED <b>12/27/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec 29 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter And Paul</b>	24d. LOCATION (City, town, or county) <b>St. Louis</b>	(State) <b>Mo.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 28 1953</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>McCollen's Funeral Home</b> ADDRESS <b>10123 St. Charles Rd.</b>		

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

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**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.....  
Signature of Student Embalmer

Signed *W. Wilkinson*.....

Licensed Embalmer No. *35*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.