

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21404

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5047

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 town) OR TOWN St. Louis, Mo.		a. STATE Missouri	b. COUNTY
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		e. STREET ADDRESS (If rural, give location) 20 2332 B. Warren St.	2209

3. NAME OF DECEASED (Type or Print)	a. (First) Jimmy	b. (Middle) Dale	c. (Last) Walker	4. DATE OF DEATH (Month) (Day) (Year) June 5, 1954
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH July 1, 1942	9. AGE (In years last birthday) 11	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (City and State or Foreign Country) Holcomb, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Leonard Walker	13b. MOTHER'S MAIDEN NAME Beula Huddleston	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME Leonard Walker	ADDRESS 2332B Warren St.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3/15/54 to 6/5/54
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>dysphagetic leukoencephalopathy acute</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19a. DATE 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) 204.0
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?

22. I hereby certify that I attended the deceased from March 15, 1954, to June 5, 1954, that I last saw the deceased alive on June 5, 1954, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	23b. ADDRESS 1901 Napoleon St. Lawton, Mo	23c. DATE SIGNED 6/5/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-5-54	24c. NAME OF CEMETERY OR CREMATORY Stanfield Cemetery	24d. LOCATION (City, town, or county) (State) Clarkson, Missouri.
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DATE REC'D BY LOCAL REG. JUN 7 1954	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington.
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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.....
Signature of Student Embalmer

Signed *Edward G. Lehmann*

Licensed Embalmer No. *456*

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.