

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 6 1956

State File No. **42737**  
Registrar's No. **11029**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		REGISTRAR'S NO. <b>11029</b>			
1. PLACE OF DEATH a. COUNTY _____				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>5 yrs 2 mo</b>		c. CITY OR TOWN <b>St. Louis</b>		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 <b>St. Louis Chronic Hosp.</b>				* STREET ADDRESS (If rural, give location) <b>13 5800 Arsenal St. 21370</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>L.</b> c. (Last) <b>Walker</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>12-14-55</b>						
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>2-17-1898</b>			
9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckdriver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>William Walker</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Hawkins</b>		14. NAME OF HUSBAND OR WIFE <b>xxxx Vivian</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-01-6057</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hospital Records</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>Arteriosclerotic Heart Disease Hypertension</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral Embolism</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>42010</b>		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) (Min.)		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 <b>9-28-50</b> , 19____, to <b>12-14-55</b> , 19____, that I last saw the deceased alive on <b>12-14-55</b> , 19____, and that death occurred at <b>10:40 p.m.</b> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>George M. Janaka, M.D.</b>				23b. ADDRESS <b>5800 Arsenal St.</b>		23c. DATE SIGNED <b>Dec 25, 1955</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-17-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>DEC 16 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin F.H., Inc. 2301 Lafayette</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 *H. G. Harris*.....

Licensed Embalmer No. *338*.....

P. O. Address *H. G. Harris*.....

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.