

FILED JAN 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **100**

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| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Mo. b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | c. LENGTH OF STAY (in this place) 6 hours | 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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Luke's Hospital | | e. STREET ADDRESS (If rural, give location) 5815 A Cates 20570 | |

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|-------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) E. c. (Last) WALLING | | | 4. DATE OF DEATH (Month) (Day) (Year) 1 5 56 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 3-10-91 | | 9. AGE (In years last birthday) 64 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Indiana | 12. CITIZEN OF WHAT COUNTRY? U S A |

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|-------------------------------------------|---------------------------------------------|---------------------------------------------------|
| 13a. FATHER'S NAME Joel Walling | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Ada Walling |
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|-----------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. 494-07-6279 | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Ada Walling 5815 a Cates Ave | |
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) CORONARY THROMBOSIS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PULMONARY EMPHYSEMA | | INTERVAL BETWEEN ONSET AND DEATH 2 days years years |
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION 420.0 | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |

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| 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? _____ |

22. I hereby certify that I attended the deceased from **Jan 4, 1956**, to **Jan 5, 1956**, that I last saw the deceased alive on **Jan 5, 1956**, and that death occurred at **5:30 AM.**, from the causes and on the date stated above.

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|-------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------|
| 23a. SIGNATURE (Degree or title) A. F. Montgomery, M.D. | 23b. ADDRESS St. Luke's Hospital | 23c. DATE SIGNED 1/5/56 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 1-7-56 | 24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery |
| 24d. LOCATION (City, town, or county) (State) St. Louis Co | | |

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|--------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------|
| DATE REC'D BY LOCAL REG. JAN 5 1956 | REGISTRAR'S SIGNATURE Carl Smith | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joe W. Clark Funeral Home Inc 1125 Hodiamont Ave |
|--------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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..... *Alfred J. Boedeker*
Licensed Embalmer No. *266*

P. O. Address *11257 Ave*

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.