

FILED DEC 10 1957
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11624

1. PLACE OF DEATH a. COUNTY <u>Fernum Desloge Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) <u>26 days</u>	c. CITY OR TOWN <u>St. Louis</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fernum Desloge Hospital</u>			
e. STREET ADDRESS <u>2110 3427 Washington</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Eric</u>	b. (Middle) <u>Peter</u>	c. (Last) <u>Samuelson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30 '57</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED; NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/3/1884</u>	9. AGE (In years last birthday) <u>73yo</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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 NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Desloge Hospital Records</u>	ADDRESS _____
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Respiratory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH _____
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Hypopharynx 5 mos.</u>		
	DUE TO (c) <u>Cervical Metastases</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>147X</u>			

19a. DATE OF OPERATION <u>11/9/57</u>	19b. MAJOR FINDINGS OF OPERATION <u>Metastatic Sq. cell Ca.</u>	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Illness</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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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? _____
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22. I hereby certify that I attended the deceased from 11/29/57, 1957, to 11/30, 1957, that I last saw the deceased alive on 11/30, 1957, and that death occurred at 12:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>James W. Walker M. D.</u>	(Degree or title) <u>M. D.</u>	23b. ADDRESS <u>516 Brookdale Br. Webster Groves</u>	23c. DATE SIGNED <u>11-30-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-4-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>REC 3 57</u>	REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington Blvd.</u>
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Dr. James W. Walker, M.D., Attending physician in hospital of Fernum Desloge called on case. WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DATE

TIME

NO.

NAME

ADDRESS

STREET

CITY

STATE

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. W. Wilkins*

Licensed Embalmer No. *357*

P. O. Address *U. L. L...*

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.