

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007935
State File No.

FILED MAR 5 - 1958

318

1003

2021

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 8 Hrs.		d. STREET ADDRESS (If rural, give location) 3526 Papin St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 25 City Hospital #1			
3. NAME OF DECEASED a. (First) Sam		b. (Middle)	
c. (Last) Walls		4. DATE OF DEATH (Month) (Day) (Year) Feb. 17 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 15, 1908
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	11. BIRTHPLACE (City and State or Foreign Country) Jefferson County Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Richard Walls	
13b. MOTHER'S MAIDEN NAME Fannie Jerett		14. NAME OF HUSBAND OR WIFE Alice Walls	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 430-30-7981	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alice Walls 3526 Papin St.			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>hemorrhagic softening of the brain</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>331x</i> Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
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?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on 10:15A m., from the causes and on the date stated above.

23a. SIGNATURE <i>John M. Smith</i>	23b. ADDRESS 1200 Clark	23c. DATE SIGNED 2/18/58
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 24, 1958	24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cem.
24d. LOCATION (City, town, or county) St. Louis Co.	24e. (State) Mo.	

DATE REC'D BY LOCAL REG. FEB 20 '58	REGISTRAR'S SIGNATURE <i>Paul Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE John W. Hemphill	ADDRESS 408 S. Fillmore Ave Kirkwood 22. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

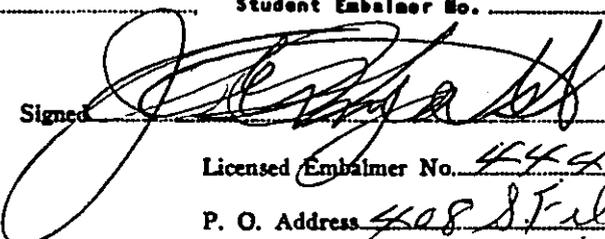
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer

Signed  _____
Licensed Embalmer No. 4441
P. O. Address 408 S. Fullmore

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 this body is not embalmed, fact should be so stated above.