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FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20839-58

58-012450

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3464

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY 2259
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST. LOUIS, MO Inside Limits Yes ☑ No ☐ 0
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 25 ST. LOUIS CITY HOSP. Length of stay in 1b #1	d. STREET ADDRESS (If outside, give location) 25 1719 O' FALLON Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: BABY GIRL Middle: Last: WALKER			4. DATE OF DEATH Month: MARCH Day: 4 Year: 1958	
5. SEX: FEMALE 3	6. COLOR OR RACE: NEGRO	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐	8. DATE OF BIRTH: 3/2/58 ✓	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days 1 IF UNDER 24 HRS.: Hours 11 Min. 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (City and state or country): ST. LOUIS, MO. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: ???	13b. MOTHER'S MAIDEN NAME: BESSIE WALKER	14. NAME OF HUSBAND OR WIFE		
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.: NONE	17. INFORMANT Address: ST. LOUIS CITY HOSP. #1.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congenital Heart Disease

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 754.5

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 1

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3/2/58, to 3/4/58 and last saw her/him alive on 3/4/58

Death occurred at 4:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Quentin C. Cox M.D.	22b. ADDRESS: 1515 Lafayette Ave.	22c. DATE SIGNED: 3/17/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 3-31-58	23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.		
24. FUNERAL DIRECTOR ADDRESS: Rowland Aker 4104 Manchester	25. DATE RECD. BY LOCAL REG.: MAR 26 '58	26. REGISTRAR'S SIGNATURE: J Earl Smith MD MSB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No.....

P. O. Address.....

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.