

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038314

STATE FILE NUMBER

FILED OCT 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

97771

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>14 JEWISH Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>147 3448 BRANNON</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>M. RALPH WALSH</u>			4. DATE OF DEATH Month Day Year <u>OCT. 9 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASS'T. CITY COUNSELOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. LOUIS Mo.</u>	9. AGE (In years last birthday) <u>57</u> FUNDER YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Mo.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>MARTIN WALSH</u>		13b. MOTHER'S MAIDEN NAME <u>KATHERINE Mc NICHOL</u>	
14. NAME OF HUSBAND OR WIFE <u>ANN WALSH</u>		15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>489-28-0381</u>		17. INFORMANT <u>ANN WALSH 3448 BRANNON</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis</u>			<u>14 days</u>
DUE TO (c) <u>420.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Sept 25, 1958</u> to <u>Oct 9, 1958</u> and last saw ^{her} him alive on <u>Oct 8, 1958</u> Death occurred at <u>7:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles Silverberg, M.D.</u>		22b. ADDRESS <u>462 N. Taylor Ave.</u>	
22c. DATE SIGNED <u>10/11/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT. 13 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo.</u>	
24. FUNERAL DIRECTOR <u>Thomas Kute 2906 Travis</u>		25. DATE RECD. BY LOCAL REG. <u>OCT. 14 '58</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Smith M.D.</u> <u>m.d.</u>			

10-1207M
Sgt.

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 *Samuel C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Duane*

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.