Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003603
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 342

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4347 Washington — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Sylvia — Middle: — Last: Walls

4. DATE OF DEATH: Month 1 — Day 7 — Year 59

5. SEX: Female 3

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-5-1918

9. AGE (In years last birthday): 40 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (City and state or country): E. CARONDELET, ILL

12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: JOHN POE

13b. MOTHER'S MAIDEN NAME: LOTTIE POE

14. NAME OF HUSBAND OR WIFE: WILBOR WALS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 330-12-8498

17. INFORMANT: WILBOR WALS — Address: 705 BONANT ST

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): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Lupus Erythematosus

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.)

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 1-2-59, to 1-7-59 and last saw her/him alive on 1-7-59
Death occurred at 2:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. A. Fraser, M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 1-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 1-13-59

23c. NAME OF CEMETERY OR CREMATORY: FATHER DICKSON

23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY MO

24. FUNERAL DIRECTOR — ADDRESS: PEASTON FUNERAL 3615 EASTON

25. DATE RECD. BY LOCAL REG.: JAN 12 '59

26. REGISTRAR'S SIGNATURE: J Earl Smith MD MPB

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.