

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007752  
STATE FILE NUMBER  
2 1878  
Registrar's No.

FILED MAR 10 1959

Registration District No. Primary Registration District 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, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 St. Louis State Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5400 Arsenal St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last HARVEY WALKER			4. DATE OF DEATH Month Day Year Feb. 19, 1959		
---	--	--	---	--	--

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ?? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1900	9. AGE (In years last birthday) 58	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) ???	10b. KIND OF BUSINESS OR INDUSTRY ???	11. BIRTHPLACE (City and state or country) Kentucky /	12. CITIZEN OF WHAT COUNTRY? U.S.A
--	--	--	---------------------------------------

13a. FATHER'S NAME Larry Walker	13b. MOTHER'S MAIDEN NAME Mary (Moore)	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) ??	16. SOCIAL SECURITY NO. ????	17. INFORMANT Society of St. Vincent Depaul 2331 Mullanphy	Address
---	---------------------------------	---	---------

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>Confluent bronchial pneumonia, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetes mellitus</u>	
	DUE TO (c) <u>260XB</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Syphilis</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>Nov. 24, 1958</u> to <u>Feb. 19, 1959</u> and last saw him alive on <u>Feb. 19, 1959</u> Death occurred at <u>11:35</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <u>R. Hofstetter, M.D.</u>	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 2-20-59
--	----------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/23/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
---	----------------------	--	--

24. FUNERAL DIRECTOR C.W. Roberts Und. Co 1416 N. Taylor Ave	25. DATE RECD. BY LOCAL REG. FEB 22 59	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 James A Carter  
Licensed Embalmer No. 11651  
P. O. Address 11651

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.