

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019738

STATE FILE NUMBER
2 5138

FILED JUN 4 1959 Registration District No. Primary Registration District No. Registrar 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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1512 No. Grand	

3. NAME OF DECEASED (Type or print) Marion Walker			4. DATE OF DEATH Month 4 Day 26 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-05	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Miss.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME George Walker	13b. MOTHER'S MAIDEN NAME Mattie	14. NAME OF HUSBAND OR WIFE Eloise Walker
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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 Mrs. Mary D. Jett	Address R.R.L. 2601 Whittier St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: epidermoid carcinoma of tongue with malnutrition		INTERVAL BETWEEN ONSET AND DEATH undet.
IMMEDIATE CAUSE (a) epidermoid carcinoma of tongue = malnutrition		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	141.9
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 <input type="checkbox"/> NO <input checked="" 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.)
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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 St. Louis, Mo.	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from 3-9-59 to 4-26-59 and last saw ^{her} alive on 4-26-59 Death occurred at 6:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lemuel C. Clanton (Print name or title) <i>Lemuel C. Clanton, M.D.</i>	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-30-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL HOME OR SERVICE Rowland Aker Mortuary Service 1104 Manchester Ave. ST. LOUIS 10, Mo.	25. DATE RECD. BY LOCAL REG. MAY 28 59	26. REGISTRAR'S SIGNATURE <i>Mrs. Carl Smith, M.D.</i>
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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

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.