

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 21 1959

'59 0 4 6 3 1 2
 STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3188

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u>		Length of stay in 1b <u>DAYS</u>	c. CITY OR TOWN <u>AFTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GLENWOOD NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8510 SKYLINE DR.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE A WALKER</u>			4. DATE OF DEATH Month Day Year <u>Nov 30 1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1878</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY EMPLOYEE</u>	11. BIRTHPLACE (City and state or country) <u>WATSENA, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>-----WALKER</u>		13b. MOTHER'S MAIDEN NAME <u>-----DUNLAP</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>488-07-2216</u>	17. INFORMANT Address <u>RUTH SILVER 8510 SKYLINE DR.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>cardiac insufficiency</u>			<u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>hypostatic pneumonia</u>		<u>4 days</u>
	DUE TO (c) <u>cerebral vascular accident</u>		<u>11 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Caused by arteriosclerosis of coronary arteries and heart disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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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.)			
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 10-1-59 to present and last saw her/him alive on 11-30-59
 Death occurred at 1242 PM 11-30-59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thomas T. J. [Signature]</u>		22b. ADDRESS <u>1300 Paul Rd. St. L. 19. Mo.</u>		22c. DATE SIGNED <u>12-1-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/3/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., Mo.</u>	

24. FUNERAL DIRECTOR ADDRESS <u>J L ZIEGENHEIN & SONS 7027 GRAYOIS</u>		25. DATE RECD. BY LOCAL REG. <u>12-1-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald Benji

Licensed Embalmer No. 4763

P. O. Address LA Fourn MEO

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.