

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960



Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-1540-60-009026** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1		d. STREET ADDRESS (If outside, give location) 4225 E. Page	

3. NAME OF DECEASED (Type or print) First Charlie Middle Walker Last Walker			4. DATE OF DEATH Month February Day 8 Year 1960		
5. SEX M	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Apr. 67	9. AGE (last birthday) 420.1	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hennings, Tenn.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Irving Walker		13b. MOTHER'S MAIDEN NAME Sarah Garner		14. NAME OF HUSBAND OR WIFE _____	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT Mrs. Floyd Bowen-4225 E. Page	Address 4225 E. Page
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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: IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 420.1	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 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 4-3-58 to 2-8-60 and last saw her alive on 2-8-60	COUNTY	STATE
21. I attended the deceased from 12:30 on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Robert M Donati MD (Degree or title)		22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 2-8-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-11-60	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) (State) Berkeley, Mo.	
24. FUNERAL DIRECTOR A.L. Beal Und. Co. - 4303 Delmar		25. DATE RECD. BY LOCAL REG. FEB 10 1960	26. REGISTRAR'S SIGNATURE Earl Smith MD	

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 Arthur L. Holliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.