

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 22 1960

60-017447

Registration District No. _____ Primary Registration District No. _____ Registrar **2 3995** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Wayne				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		c. CITY OR TOWN Fairfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GRACE L. WALKER				4. DATE OF DEATH Month Day Year APRIL 8 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/17/1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) Norris City, Illinois.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Wellington Lasater			13b. MOTHER'S MAIDEN NAME Susan McKenzie		14. NAME OF HUSBAND OR WIFE William M. Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N41 348-22-6691		17. INFORMANT Address William L. Walker, Fairfield, Illinois.				
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) ACUTE RENAL FAILURE								
DUE TO (b) LOWER NEPHRON NEPHROSIS							10 DAYS	
DUE TO (c) GASTRIC ULCERS, MULTIPLE							2-3 YEARS	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m. Month, Day, Year								
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 MARCH 31, 1960 to APRIL 8, 1960 and last saw her/him alive on APRIL 8, 1960 Death occurred at 9:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>E. J. Hamilton, M.D.</i>				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 4/8/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/9/60	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		23d. LOCATION (City, town, or county) (State) Fairfield, Illinois.				
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.,			25. DATE RECD. BY LOCAL REG. 4-9-60		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AT 11:45 AM 1/15/53

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 J. W. M. Bentley
Licensed Embalmer No. 3653
P. O. Address J. W. M. Bentley

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