

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 21 1960 318

1003

9025 - 60-036687

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE OF MISSOURI

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		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) 2819 Lafayette	
3. NAME OF DECEASED (Type or print) First Middle Last REUBEN WALKER		4. DATE OF DEATH Month Day Year SEPT. 12, 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/7/14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Man		10b. KIND OF BUSINESS OR INDUSTRY Mo. Pac. R.R.	9. AGE (last birthday) 46
11. BIRTHPLACE (City and state or country) Rector, Ark/		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME XXXK JIM Walker		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Byrdie 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. 489 09 32 88		17. INFORMANT Byrdie Walker, 2819 Lafayette (4)	
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>Gastrointestinal hemorrhage</u> DUE TO (b) <u>Esophageal varices</u> DUE TO (c) <u>Cirrhosis of liver (Laennec's)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pancreatitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs</u> <u>4 yrs</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.)	
21. I attended the deceased from <u>9/9/60</u> to <u>9/12/60</u> and last saw her <u>9/22/60</u> Death occurred at <u>6:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
22a. SIGNATURE (Degree or title) <u>W. Yates Trotter, M.D.</u>		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 9/12/60		23. NAME OF CEMETERY OR CREMATORY St. Trinity	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION Buried (Type in box) REMOVED		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette (4)		25. DATE RECD. BY LOCAL REG. SEP 13 1960	
26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>			

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 _____

Licensed Embalmer No. 455

P. O. Address H. Fournier

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.