

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, MO		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5615 Vernon
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WALTER Middle Last WELLS			4. DATE OF DEATH OCT. 4, 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-11-1911	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Century Electric Co.	11. BIRTHPLACE (City and state or country) Transylvania, La	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ned Wells		13b. MOTHER'S MAIDEN NAME Harriett Green		14. NAME OF HUSBAND OR WIFE - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW II		16. SOCIAL SECURITY NO. 437-12-3891	17. INFORMANT Joe E. Wells - 5615 Vernon Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH 9 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 331x	
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 9/25/60 to 10/4/60 and last saw her/him alive on 10/4/60 Death occurred at 7A m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>Willy J. Weinstein M.D.</i>		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 10/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-11-60	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR Atkins Bros.	ADDRESS 3644 Finney Ave.	25. DATE RECD. BY LOCAL REG. OCT 6 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>	

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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Cunningham
Licensed Embalmer No. 447

P. O. Address 2405 Marcus

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