

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			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. Johns Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5271 Beacon Ave.
3. NAME OF DECEASED (Type or print) First CLARA Middle WALSH Last			4. DATE OF DEATH Month DEC. Day 5 Year 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 11/28/1903	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles Reichenbach		13b. MOTHER'S MAIDEN NAME Bertha Jungmann		14. NAME OF HUSBAND OR WIFE Frank Walsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *****		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Walsh 5271 Beacon Ave.	
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) Pulmonary edema					12 hrs
DUE TO (b) Myocardial degeneration ^{atherosclerosis}					3 years
DUE TO (c) Diabetes mellitus 26+ 20 yrs					20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not refer to the terminal illness or condition) Left hemisphere cerebral vascular damage					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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 9/36 to 12/5/60 and last saw her alive on 12/4/60 Death occurred at St. Johns Hospital 10 PM of the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>(Signature)</i>			22b. ADDRESS 29 N. Mevarec		22c. DATE SIGNED 12/8/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis Mo.
24. FUNERAL DIRECTOR JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.			25. DATE RECD. BY LOCAL REG. DEC 8 1960	26. REGISTRAR'S SIGNATURE <i>(Signature)</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Mich. S. ...
P.O. ...
19...*

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.M. Pister*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

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.