

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046511

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11483** STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis Little</b> INSTITUTION <b>Rock Hospital Inc</b>		d. STREET ADDRESS (If outside, give location) <b>1219 South Compton</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>King</b> Last <b>King</b>	4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1961</b>
------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1907</b>	9. AGE (last birthday) <b>54</b>	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) <b>Janitor-Union Station (Pens)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Unk</b>	12. CITIZEN OF WHAT COUNTRY
------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------	----------------------------------------------------------	-----------------------------

13a. FATHER'S NAME <b>Willie King</b>	13b. MOTHER'S MAIDEN NAME <b>Mattie Pettie</b>	14. NAME OF HUSBAND OR WIFE <b>Emma Louise King</b>
------------------------------------------	---------------------------------------------------	--------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	17. INFORMANT Address <b>Emma Louise King 1219 S. Compton</b>
----------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------

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) <b>Congestive Heart Failure</b>		<b>24 hr</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>2 yrs</b>
DUE TO (c) <b>Generalized Arteriosclerosis</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Pyelonephritis 420's</b>		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
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

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 <b>3:50 A</b> Month, Day, Year <b>Dec. 7, 1961</b>	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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>MO</b>
--------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------	----------------------------	--------------------

21. I attended the deceased from <b>3:50 A</b> to <b>Dec. 7, 1961</b> and last saw him/her alive on <b>12/6/61</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE (Degree or title) <b>Masao Okamoto M.D.</b>	22b. ADDRESS <b>1755 S. Grand Blvd.</b>	22c. DATE SIGNED <b>12/8/61</b>
---------------------------------------------------------------	--------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-11-61</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co MO</b>
--------------------------------------------------------------	-----------	--------------------------------------------------------------	-------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Watson Funeral Home 2700 Chouteau</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 8 1961</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith M.D.</b>
------------------------------------------------------------------	---------------------------------------------------	-----------------------------------------------------

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*James A Carter*

Licensed Embalmer No. 681

P. O. Address St. Louis

\* 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.