

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046961

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12052**

AMENDED

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b Yes <input type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUN St.Louis		c. CITY OR TOWN Webster Groves d. STREET ADDRESS (If outside, give location) 651 W.Lockwood	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis		Length of stay in 1b Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Groves		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St.Lukes Hospital		Length of stay in 1b Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 651 W.Lockwood		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First EMMA Middle MAY Last WALKER			4. DATE OF DEATH Month Dec. Day 21, Year 1961		
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5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1872	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) Decatur Co., Ind.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Barger	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James Henry Walker
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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. None	17. INFORMANT Clyde Walker 127 Trevillian
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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 8 days
IMMEDIATE CAUSE (a) Cardiac decompensation	DUE TO (b) arteriosclerotic heart disease	15 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) generalized arteriosclerosis	over 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 4200
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **9/29/45** **to** **12/21/61** **and last saw her** **per** **alive on** **12/21/61**
Death occurred at **9:35** **p.m.** **on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE (Degree or title) David M. Skilling, Jr. M.D.	22b. ADDRESS 18 So. Kingshighway, St. Louis	22c. DATE SIGNED 12/22/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 12-23-1961	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves Mo.	25. DATE RECD. BY LOCAL REG. DEC 22 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

Cremation

DEC 22 1961

Loan Smith, M.D.

No. 1503

Maple Grove
St. Louis, Mo.

St. Louis

St. Louis

Dec. 31, 1961

MALE

12-12-1878

W

W

W

Assoc. Co. Ind. USA

at home

Monmouth

James Henry Walker

Unknown

Partner

Clyde Walker 127 Trevelian

None

MO

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 *Leslie Welch*

Licensed Embalmer No. 4395

P. O. Address Maple Grove

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, it should be so stated above.

Maple Grove