MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-047837

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12472

FILED JAN 19 1962

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: 4 yrs.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 1 mo. 20 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3225 Montgomery St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Walter Middle Last Wallace
4. DATE OF DEATH: Month 12 Day 21 Year 61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 8-31-98
9. AGE (last birthday): 63
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): UNK.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: unk.
13b. MOTHER'S MAIDEN NAME: unk.
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNK (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNK.
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Epidermoid Carcinoma, pharynx c metastases.
INTERVAL BETWEEN ONSET AND DEATH: ? 24 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 148X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease – Malnutrition

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 11-1-56, to 12-21-61 and last saw her/him alive on 12-21-61
Death occurred at 2:00 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John J. Kenny (Degree or title) MD.
22b. ADDRESS: 5800 Arsenal Ave
22c. DATE SIGNED: 12-22-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Rowland-Aker Mortuary Service
23b. DATE: 1-31-62
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: 4104 Manchester Ave. St. Louis 10, Mo.
25. DATE RECD. BY LOCAL REG.: JAN 11 1962
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.