

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021110

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4741 STATE FILE NUMBER

FILED MAY 23 1962

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 50 yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4209 W. Maffitt Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Katie Walker
 4. DATE OF DEATH Month Day Year
5 7 62
 5. SEX Female 6. COLOR OR RACE Negro 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 10-12-91 9. AGE (last birthday) 70 yrs. 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____
 11. BIRTHPLACE (City and state or country) Larmon Miss. 12. CITIZEN OF WHAT COUNTRY U.S.A.
 13a. FATHER'S NAME Thornton Perkins 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) (If yes, give war or dates of service) No. 16. SOCIAL SECURITY NO. _____
 17. INFORMANT Robert Washington Address 4734 Newcomb Pl.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH Undet.
 (b) Hypertensive Cardiovascular Disease Undet.
 (c) 443x

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.
 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 4-22-62 to 5-7-62 and last saw her ^{him} alive on 5-7-62
 Death occurred at 7:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sydney A. Frase, M.D. 22b. ADDRESS 2601 N. Whittier Street 22c. DATE SIGNED 5-8-62

23. BURIAL, CREMATION, REMOVAL (Specify) Rem. 23b. DATE 5-11-62 23c. NAME OF CEMETERY OR CREMATORY Washington Park 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS Manuel Und. Co. 1711 N. Taylor 25. DATE RECD. BY LOCAL REG. MAY 9 1962 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

VS 300 Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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21/9

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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,
X or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *H. Claude Gordon*

Licensed Embalmer No. 3489

P. O. Address 1125 N. Taylor

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.