

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036830

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9420 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 11 1962

VS 300
Rev. 4/59

1

2 20

3

4 0

5 1

6

7 0

8 1

9

10

11

12 65-0

13

DATE AMENDED
11-17-62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
11-5-78 + 83

ITEM NO. SHOULD READ
849 11-5-88 + 73

DOCUMENT
From birth record

By Affidavit of Funeral Director

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6108 WANDA</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR W WALKER</u>						4. DATE OF DEATH Month Day Year <u>SEPT 28 1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 5 1878</u>		9. AGE (last birthday) <u>83 7/3</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FOREMAN RAILWAY EXP.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI</u>				12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>			
13a. FATHER'S NAME <u>WILLIAM WALKER</u>				13b. MOTHER'S MAIDEN NAME <u>JANE MILLS</u>				14. NAME OF HUSBAND OR WIFE <u>ROXIE WALKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ROXIE WALKER 6108 WANDA</u>					
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) <u>Congestive Cardiac Failure</u>											
DUE TO (b) <u>-marked- Cardiac Enlargement</u>											
DUE TO (c) <u>+ Pulmonary Edema, art. sclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes, Bilateral Pleural Effusion</u>										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 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.) <u>434.4</u>							
20c. TIME OF INJURY Hour a.m. p.m.		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 <u>Sept 17, 1962</u> to <u>Sept 28, 1962</u> and last saw him alive on <u>Sept 28, 1962</u> Death occurred at <u>6:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Deceased or title) <u>Herbert H. Kuter, M.D.</u>						22b. ADDRESS <u>3532 Gravois Ave</u>			22c. DATE SIGNED <u>10/1/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT 3 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>					
24. FUNERAL DIRECTOR <u>Thomas Kuter 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 2 1962</u>		26. REGISTRARS SIGNATURE <u>Paul Smith M.D.</u>					

Dr. W. H. ...

3532 Alameda

PR-2-3338

130-40th man.

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 *Robert H. ...*
Licensed Embalmer No. *4861*

P. O. Address *St. Louis 19, 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.