

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

10683-62-045026  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10683**

**FILED NOV 19 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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2 **21**  
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4 **0**  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	6. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>	Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3224A Henrietta</b>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Walsh</b>				4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1962</b>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <b>1</b> Days <b>5</b> IF UNDER 24 HR: Hours <b>1</b> Min. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Thomas William Walsh</b>				13b. MOTHER'S MAIDEN NAME <b>Jane Dolores Dwyer</b>		14. NAME OF HUSBAND OR WIFE <b>Thomas William Walsh, 3224A Henrietta St. Louis, Mo.</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <b>No</b> or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Thomas William Walsh, 3224A Henrietta St. Louis, Mo.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital deformity</b> DUE TO (b) <b>Impure air being breathed</b> DUE TO (c) <b>756.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH				
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. <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>2 p.m.</b> Month, Day, Year		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 <b>12:50 p</b> <b>Nov. 6</b> , to <b>2 p.m</b> <b>Nov. 6</b> and last saw her alive on <b>2 p.m</b> <b>Nov. 6</b> 1962 Death occurred at <b>2 p.m</b> m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <b>L.M. Rindan</b> (Degree or title)				22b. ADDRESS <b>Lester Berg</b>				22c. DATE SIGNED <b>11/7/62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 7, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		(State)				
24. FUNERAL DIRECTOR <b>E.J. Schnur</b> ADDRESS <b>3125 Lafayette</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 7 1962</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>						

USE BLACK INK OR TYPEWRITER RIBBON

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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,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph J. Vallone  
*NOT EMBALMED*

Licensed Embalmer No. \_\_\_\_\_  
P. O. Address 3125 Lafayette

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.