MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35114

File No. .....

Registered No. 10265

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Sanitarium St. ..... Ward)

2. FULL NAME Nelson Walters

(a) Residence. No. 5800 Arsenal St., 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Annie Sullivan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 19, 1848

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	79	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Sweden
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Mathias Walters

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Anna Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Sweden

14. INFORMANT Mrs. Effinger
(Address) 5800 Arsenal

15. FILED NOV 16 1927, 19..... Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 15 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov 15, 1927, that I last saw him alive on Nov 15 1927, and that death occurred, on the date stated above, at 2:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Cerebral Embolism
2. Myocarditis.
3. 430
4. 332 B
5. 97

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ?

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Fixed Pupils

(Signed) No legal signature Kenneth L. Hand, M. D.

Nov. 16, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary Cem.	Nov. 17, 1927

20. UNDERTAKER	ADDRESS
Jas. W. Clark	1120 Hodiamont Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.