

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

Do not use this space.

32168
9215

1. PLACE OF DEATH

County.....*St Louis*..... Registration District No. *791*
Township.....*Bayard*..... Primary Registration District No. *1003*
City.....*St Louis* (No. *1115*)..... St. Ward) (Registered No. *9215*)

2. FULL NAME

(a) Residence No. *1115 Bayard at St.* *12* Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *Madge Walter*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *8/12-1870*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 | *1* | *2*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Emmanuel Inspector*
(b) General nature of industry, business, or establishment in which employed (or employer) *Store and Range*
(c) Name of employer *Charles Oak Store Co*

9. BIRTHPLACE (CITY OR TOWN) *St. Dakota*
(STATE OR COUNTRY)

10. NAME OF FATHER *Edward Walter*

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

12. MAIDEN NAME OF MOTHER *Jennie Schaefer*

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

14. INFORMANT *Madge Walter*
(Address) *1115 Bayard St.*

15. FILED *SEP 15 1929* REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 14 1929*

17. I HEREBY CERTIFY, That I attended deceased from *July 2* 19*28*, to *Sept 14* 19*29*, that I last saw him alive on *Apr 13* 19*29*, and that death occurred, on the date stated above, at *7:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis - Chron.
131
93C
102 (duration) yrs. *?* mos. *?* ds.

CONTRIBUTORY (SECONDARY) *Chronic Nephritis*
Arteriosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *159 W*

0 DID AN OPERATION PRECEDE DEATH *no* DATE OF *no*

19. WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *R. G. Green*, M. D.
Yates Bld. 4800 Ohio

*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calhoun Crematory* DATE OF BURIAL *9/16 1929*

21. UNDERTAKER *Meek & Dickman* ADDRESS *3039 Eastm*

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.

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