

Form No. 28
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1940 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 7 - 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8178

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 347

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights
(c) Name of hospital or institution:
1220 Sunset Dr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 1220 Sunset Dr.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Walburga Weltin 435
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 17 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 10 0 _____ hr. _____ min.

9. Birthplace Quincy Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name August Sickenger

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Dehner

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. W. Wismann

(b) Address 1220 Sunset Dr.

17. (a) Removal (b) Date thereof 2-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quincy, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 18 1940 (b) J. R. ...
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 17
year 1940 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb 17, 1940, to Feb 17, 1940;
that I last saw her alive on Feb 17, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Ch Myocarditis

Due to Senility

Other conditions 93c
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Ad ... (M. D. or other) 1164

Address 2342 ... Date signed 2/18/40

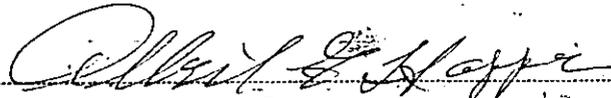
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 2971

P. O. Address.....

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 this body is not embalmed, above space should be left blank.