DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9389

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2872

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4253a Cleveland
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME August G. Walz

3. (b) If veteran, name war ----

3. (c) Social Security No. ----

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mollie Walz

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased December (Month) 11 (Day) 1877 (Year)

8. AGE: Years 62 Months 3 Days 16 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business

FATHER 12. Name August Walz

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

MOTHER 14. Maiden name Niest

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

16. (a) Informant's own signature Albert Walz

(b) Address 4253a Cleveland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wacker-Feldente

(b) Address 2331 S. Broadway

19. (a) MAR 28 1940 (Date received local registrar) (b) J. F. Buchek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 27 year 1940 hour 9 minute 15 a. M.

21. I hereby certify that I attended the deceased from Feb. 6, 1940, to Mar. 27, 1940; that I last saw him alive on Mar. 26, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chr. Myocarditis As. V. Lobarum. Cir. Cirr. of Liver. Syphilis.	3 mos.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature D. L. Hoch (M. D. or other)

Address 1115 S. Grand Date signed 3/27/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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.....

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.