

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34641

State File No. _____

Registrar's No. 83

Registration District No. 116

Primary Registration District No. 3020

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

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington
(c) Name of hospital or institution: St. Francis Hospital
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution yes - 79 days
(Specify whether years, months or days) 35 years

3. (a) PRINT FULL NAME Amanda Walther
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female 5. Color of White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband Julius Walther 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased July 23 1854
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 20 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Ferdinand Kempf

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

14. Maiden name Unknown

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

16. (a) Informant Armin Klemm

(b) Address Washington, Missouri

17. (a) Burial (b) Date thereof Oct. 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo.

18. (a) Signature of funeral director Richard W. W. Inc.
(b) Address Washington, Mo.

19. (a) 10/14/43 (b) Lucille Walter Brooks
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town Washington
(If outside city or town limits, write "RURAL")
(d) Street No. 1 West Fourth St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓ ✓ ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 13
year 1943 minute 45 P. M.
21. I hereby certify that I attended the deceased from 1925
to Oct. 13 1943
that I last saw him alive on Oct. 13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Infarction of apex
Duration 10 hrs.

Due to _____
Due to _____
Other conditions ✓ 938
(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)
(c) Means of injury _____
23. Signature May (M.D. or other) MA
Address Washington, Mo. Date signed 10/14/43

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

working under my personal supervision.

Lester A. Vitt

Registered Apprentice No.

Signed

Lester A. Vitt

Licensed Embalmer No. *3254*

P. O. Address

Washington, Mo.

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, fact should be so stated above.