

FILED JAN 12 1944

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Parklane Hospital  
(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)

3. (a) PRINT FULL NAME Walter F. Trueblood

3. (b) If veteran, name war Unknown

3. (c) Social Security No. 496-09-2363

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife UNKNOWN

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

7. Birth date of deceased October 22 1893  
(Month) (Day) (Year)

8. AGE: Years 50 Months 2 Days 9  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Gaylord Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Accountant

11. Industry or business Amertorp Corporation

MOTHER FATHER { 12. Name D.W. Trueblood

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

14. Maiden name Evelyn Prince

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

16. (a) Informant Capt. Wayne Trueblood

(b) Address Fort Worth Texas

17. (a) Removal (b) Date thereof 1/1/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Fred M. Williams

(b) Address 4535 Washington Blvd.

19. (a) Jan 31 1944 (b) J. F. Brubaker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4517 Kensington Ave. (If rural, give location) 91

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Decr day 31  
year 1943 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from 12/20/43  
\_\_\_\_\_ 19\_\_\_\_, to 12/31/43 19\_\_\_\_,  
that I last saw him alive on 12/31/43  
and that death occurred on the date and hour stated above.

Immediate cause of death degeneration of liver  
Due to alcohol  
Due to 12/4

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Hepatic cirrhosis  
acute hepatitis - Red Stain

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature A. William Pohl (M.D. or other) MD  
Address 5101 Delmar Rd Date signed 12/31/43

Duration 400

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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**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.

Signed

*John Ignowski*  
Registered Apprentice No.....  
Licensed Embalmer No. *2398*  
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, fact should be so stated above.