

7. S. No. 2
00M-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15066

FILED MAY 26 1945

Registrar's No. 4467

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:
11811 E. Prairie Ave.
(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 Louis Dreher

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Ann Dreher

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Feb. 5. 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>3</u>	<u>12</u>hr.min.

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

10. Usual occupation None

11. Industry or business.....

MOTHER FATHER

12. Name Peter Dreher

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Ann Dreher

(b) Address 1811 E. Prairie Ave.

17. (a) Burial (b) Date thereof 5/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Blvd

19. (a) MAY 21 1945 (b) J. F. Bedeak
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 1811 E. Prairie Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1945 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4-17-42
....., 19....., to 5-17-45....., 19.....;

that I last saw him alive on 5-17-45....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to Hypertension

Due to Nephritis, Chronic

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration 5 mo.

Do not know

Do not know

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

Signature Russell Shaver (M.D. or other) DO

Address 4032 W. Flannery Date signed 5-19-45

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

Frank A. Morrison

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.