

FILED SEP 7 1945 STANDARD CERTIFICATE OF DEATH

State File No. 7652

Registration District No. 312

Primary Registration District No. 1002

Registrar's No.

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: De Paul Hospital 0  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 5

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

(d) Street No. 5966 a Plymouth Ave 9  
(If rural, give location)

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

3. (a) PRINT FULL NAME Walter R. Duffer

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0 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 16, 1881  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31, 1945  
year 4 hour 30 minute A M.

21. I hereby certify that I attended the deceased from 21 to 31 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 10 Days 15  
If less than one day hr. min.

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

10. Usual occupation Auditor

11. Industry or business St. Louis Police Dept.

Immediate cause of death: Septic Abscess (multiple) 2

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 125  
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name James F. Duffer

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

14. Maiden name Sarah I. Coudy

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

16. (a) Informant Mrs. Dudley E. Waters  
(b) Address 508 West Drive

17. (a) Burial (b) Date thereof Sept 3, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Shepard Funeral Home  
(b) Address 1167 Hamilton Avenue

19. (a) SEP 1 1945 (b) J. F. Braddock  
(Date received local registrar) (Registrar's signature)

Major findings: 125  
Of operations \_\_\_\_\_

Of aneurysm \_\_\_\_\_

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) (Means of injury)

23. Signature J. F. Braddock (M. D. or D.O.)  
Address 496 1/2 Adams Date signed 9/31/45

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

**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

*John Agorski*

Licensed Embalmer No. *3398*

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.**