

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 1 1945 18

Registration District No.

Primary Registration District No. 1003

Registrar's No. 7384

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:
5108 North 20 Str.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 100

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

(d) Street No. 5108 No. 20th Str.
(If rural, give location)

(e) Citizen of foreign country?..... No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Herman Waeltermann

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 0 5. Color or race White

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

6. (b) Name of husband or wife Mary Waeltermann 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Nov. 11, 1859
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>85</u>	<u>9</u>	<u>13</u>	hr. min.

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

10. Usual occupation Retired

11. Industry or business Glass Maker

12. Name Jacob Waeltermann

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

14. Maiden name Elizabeth Kreiner

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

16. (a) Informant John B. Waeltermann

(b) Address 4019 N. 22 Str.

17. (a) Burial (b) Date thereof 8/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul

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

(b) Address 2117 E. Grand Blvd.

19. (a) AUG 24 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1945 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from 1930, 19....., to 8/24/45, 19.....;
that I last saw him alive on 8/24/45, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis Duration 12 yrs

Due to Senility

Due to..... 93 d.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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.....

23. Signature [Signature] (M. D. or other).....

Address 1807 W. Louisiana Date signed 8/24/45

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

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17
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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.....

.....; Registered Apprentice No.....
working under my personal supervision.

Signed

Frank A. Moore

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.