

FILED DEC 17 1946  
#63296  
518

Primary Registration District No. 1003

Registrar's No. 10274

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(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 MO (b) County.....  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4253 CLEVELAND AVE.  
Memorial (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1st  
year 1946 hour 2:50 minute A M.  
21. I hereby certify that I attended the deceased from 10/2/46  
....., 19....., to 12/1/46 19.....;  
that I last saw him im alive on 12/1/46 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chr. Jaundice  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations.....  
Of autopsy.....  
As above.

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?

18. (a) Signature of funeral director KRIEGSHAUSER UND  
(b) Address 4258 SO KINGSHIGHWAY  
23. Signature J. Z. Bressler (Specify type of plac) While at work (c) Means of injury  
Address 1515 Lafayette Date signed 12/2/46

3. (a) PRINT FULL NAME ALBERT WALZ  
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 SINGLE  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased FEB. 2 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 9 29 hr. min.

9. Birthplace ST. LOUIS MO. -G  
(City, town, or county) (State or foreign country)

10. Usual occupation LAWYER (RETIRED.)

11. Industry or business.....

12. Name AUGUST WALZ

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

14. Maiden name CATHERINE NIEST

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

16. (a) Informant GRACE C VESPA

(b) Address 4253 CLEVELAND AVE.

17. (a) BURIAL (b) Date thereof 12 3 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director KRIEGSHAUSER UND

(b) Address 4258 SO KINGSHIGHWAY

19. (a) DEC 2 1946 (b) J. Z. Bressler  
(Date required local registrar) (Registrar's signature)

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 *Richard W. Stovesand*

Licensed Embalmer No. *4007*

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.**