

National Office of Vital Statistics
FILED # 286 4 3087
Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County: **St. Louis, Missouri.**
(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: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **25 days**
(Specify whether years, months or days) **85 years**

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.: **1525 Missouri**
(If rural, give location) **9**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME: **JOHN WALTERS**
3. (b) If veteran, name war: **no**
3. (c) Social Security No.: **488-30-3133**
4. Sex: **male** 5. Color or race: **white**
6. (a) Single, widowed, married, divorced: **widowed**
6. (b) Name of husband or wife: **Ann**
6. (c) Age of husband or wife if alive: **deau 78** years
7. Birth date of deceased: **February 9th. 1862**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **19th**
year **1947** hour **12:30** minute **A.M.**
I hereby certify that I attended the deceased from **June 24** 19. **27** to **July 19th.** 19. **47**
that I last saw him alive on **July 19th.** 19. **47**
and that death occurred on the date and hour stated above.
Duration

8. AGE: Years **85** Months **5** Days **10**
If less than one dayhr.min.

Immediate cause of death: **Aspiratory failure**
Due to: **Pneumonia**
Due to: **Paralysis of lower extremities due to TRANSVERSE MYELITIS**
Other conditions: (Include pregnancy within 3 months of death)

9. Birthplace: **St. Louis Mo.** (City, town, or county) (State or foreign country)
10. Usual occupation: **Salesman**
11. Industry or business: **soda & Soft Drinks**
12. Name: **Carl Walter**
13. Birthplace: **Germany** (City, town, or county) (State or foreign country)
14. Maiden name: **Margaret E. Margander**
15. Birthplace: **Germany** (City, town, or county) (State or foreign country)
16. (a) Informant: **May Debrecht (Daughter)**
(b) Address: **4048 E. Iowa Ave.**
17. (a) Burial: **Burial** (b) Date thereof: **7/21/1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Lakewood Park**
18. (a) Signature of funeral director: **Alfred J. Weidmuller**
(b) Address: **6203 Grayois Ave.**
19. (a) **JUL 20 1947** (Date received local registrar)
(b) **J. F. Erick** (Registrar's signature)

Major findings: Of operations: **fh**
Of autopsies: **fh**
PHYSICIAN: _____
Underline the cause of 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? (Specify type of place)
23. Signature: **Paul J. Martin, MD**
1515 Lafayette (City or town) (State)
Date signed: **8/7/1947**

JUL 14 1949

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.....

Elmo R. Caldwell

Licensed Embalmer No.....

4027

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.