S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29630

FILED SEP 2 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7978

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: 4981 COLUMBIA 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Dow

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

(d) Street No. 4981 COLUMBIA AVE 9
(If rural, give location)

(e) Citizen of foreign country? 13 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MATTIE B. WALLER

3. (b) If veteran, name war W

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife SMITH WALLER

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

7. Birth date of deceased NOVEMBER (Month) 24 (Day) 1875 (Year)

8. AGE: Years 71 Months 8 Days 26 If less than one day hr. min.

9. Birthplace VERSAILLES, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business AT HOME

FATHER
12. Name UNKNOWN COLVIN
13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant GLENN WALLER
(b) Address 6909 OLEATHA AVE

17. (a) REMOVAL (b) Date thereof AUG 23, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VERSAILLES, MISSOURI

18. (a) Signature of funeral director WM J. ROBERT L. + U. Co
(b) Address 1905 SO. GRAND BLVD

19. (a) AUG 22 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 20 year 1947 hour 8 minute 25 P M.

21. I hereby certify that I attended the deceased from 1940, 19, to 8/20 47, 19; that I last saw her alive on 8/20-47, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 do.
Due to Arteriosclerosis	
Due to Hypertension	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 1602 S Bad Date signed 8/21/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....Ronald Yehnke.....

Licensed Embalmer No.....3917.....

P. O. Address.....St. Louis.....

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.