

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14399**  
Registrar's No. **237**

|   |  |  |                         |   |  |   |  |   |  |
|---|--|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>6572</b>   |                         | PRIMARY REG. DIST. NO. <b>6576</b>  |  | Registrar's No. <b>237</b>  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St Louis</b>  |  |  |                         | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>St Louis</b> |  |   |  |   |  |
| b. CITY OR TOWN <b>Oreland</b>  |  | c. LENGTH OF STAY (In this place)  |                         | c. CITY OR TOWN <b>Oreland</b>  |  | 113   |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>9700 Bristol</b>   |  |  |                         | d. STREET ADDRESS (If rural, give location) <b>9200 Bristol</b>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Julia</b>  |  |  | b. (Middle) <b>WALZ</b> |   |  | c. (Last)   |  |   |  |
| 4. DATE OF DEATH (Month) (Day) (Year) <b>3-24-49</b>  |  | 5. SEX <b>FEMALE</b>   |                         | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>                 |  |   |  |
| 8. DATE OF BIRTH <b>JUL 10 1864</b>   |  | 9. AGE (In years last birthday) <b>84</b>  |                         | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>                          |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>X</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country) <b>STONEY Hill MO</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                         | 13a. FATHER'S NAME <b>BEN JACOB</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>MARY KOELLER</b>   |  |   |  |
| 14. NAME OF HUSBAND OR WIFE <b>PETER WALZ</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>                            |                         | 16. SOCIAL SECURITY NO. <b>NONE</b>   |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Caroline Maechel</b> ADDRESS <b>9700 Bristol</b> |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><b>Coronary Occlusion</b>  |  |  |                         | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>                             |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> |  |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |  |  |                         | ANTECEDENT CAUSES<br>DUE TO (b) <b>Hypertension</b>   |  |   |  | years -                                       |  |
|   |  |  |                         | DUE TO (c) <b>Arteriosclerosis</b>  |  |   |  | 42 <sup>01</sup> years -                      |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Senile condition</b>   |  |  |                         |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |                         |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                         | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                         | 21f. HOW DID INJURY OCCUR?  |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1 - 1949</b> , to <b>3-24</b> , 1949, that I last saw the deceased alive on <b>3-22</b> , 1949, and that death occurred at <b>12:30</b> m., from the causes and on the date stated above. |  |  |                         |   |  |   |  |   |  |
| 23a. SIGNATURE (Degree or title) <b>Prof. A. A. Hatcher M.D.</b>  |  |  |                         | 23b. ADDRESS <b>2438 Woodson Rd Overland</b>  |  | 23c. DATE SIGNED <b>1744-24-49</b>  |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24b. DATE <b>3-26-49</b>   |                         | 24c. NAME OF CEMETERY OR CREMATORY <b>ST Josephs</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>LITTLE BERGER</b>                    |  |   |  |
| DATE REC'D BY LOCAL REG. <b>3-26-49</b>   |  | REGISTRAR'S SIGNATURE <b>Thurmond Longmire</b>   |                         | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>BLUMER UND, CO. HERMANN MO</b>  |  |   |  |   |  |

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

6301

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed Joseph F. Mueller

Signed.....  
Student Embalmer

Licensed Embalmer No. 3039

P. O. Address Overland Park, MO

**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.