

FILED AUG 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25743

963

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1764

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>ILLINOIS</b> b. COUNTY <b>Greene: 947</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Jefferson Barracks, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b>	
c. LENGTH OF STAY (in this place) <b>117 days</b>		d. STREET ADDRESS (If rural, give location) <b>821 Locust Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Vet. Adm. Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>H.</b> c. (Last) <b>WALTERS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 24 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 17, 1889</b>
9. AGE (in years last birthday) <b>60</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Woodville Twn, Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Unavailable</b>		13b. MOTHER'S MAIDEN NAME <b>Unavailable</b>	14. NAME OF HUSBAND OR WIFE <b>Lorraine B.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World-War-I</b>		16. SOCIAL SECURITY NO. <b>429 24 6008</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Eugene F. Nolan, Registrar Vet. Adm. Hosp. Jeff. Bks. Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>GENERALIZED LYMPHOSARCOMATOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>		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>March 29, 1949</b> , to <b>July 24, 1949</b> , that I last saw the deceased alive on <b>July 24, 1949</b> , and that death occurred at <b>4:55 pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>L. E. Stilwell, M.D. (Chf. Prof. Services)</b>		23b. ADDRESS <b>Vet. Adm. Hosp. Jeff. Bks. Mo.</b>	
23c. DATE SIGNED <b>7/25/49</b>			
24a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>		24b. DATE <b>July 25-49</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>CARROLLTON ILL</b>		24d. LOCATION (City, town, or county) (State) <b>CARROLLTON ILLINOIS</b>	
DATE REC'D BY LOCAL REG. <b>7-25-49</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffmeister</b>		ADDRESS <b>U&amp;L Co., St. Louis, Mo.</b>	
(Licensed Embalmer's Statement on Reverse Side) <b>7814 513 ROADWAY</b>			

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

A.1.L

SEP 20 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.....

.....  
working under my personal supervision.

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

Signed.....

*Leslie C. Hoffmann*

Signed.....  
Student Embalmer.....

Licensed Embalmer No. 3871

P. O. Address 2814 S. Broad

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.