

FILED NOV 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33515

BIRTH NO. _____		REG. DIST. NO. 118		PRIMARY REG. DIST. NO. 5439		Registrar's No. 40			
1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Canaan Twp.</u>		c. LENGTH OF STAY (In this place) <u>8 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Canaan Twp.</u>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Owensville / Route</u>				d. STREET ADDRESS (If rural, give location) <u>Owensville Route</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Walter</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 30 1949</u>						
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>May 10, 1878</u>			
				9. AGE (In years last birthday) <u>71</u>		10. IF UNDER 1 YEAR Months _____ Days _____			
						11. IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>***</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Nicholas J. Reiss</u>			13b. MOTHER'S MAIDEN NAME <u>Helena Adams</u>			14. NAME OF HUSBAND OR WIFE <u>George Walter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no ***</u>			16. SOCIAL SECURITY NO. <u>***</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frances Walter Owensville, Mo. R</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarct</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Arteriosclerosis, Advanced</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>2 yrs.</u> <u>2 yrs.</u> <u>4221</u>	
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) (m.)		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 <u>10-30 1949</u> to <u>10-30 1949</u> , that I last saw the deceased alive on <u>10-30 1949</u> , and that death occurred at <u>8:15 p. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Paula Brown, M.D.</u>				23b. ADDRESS <u>Owensville, Mo.</u>		23c. DATE SIGNED <u>11-1-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-3-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Catholica Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Owensville, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>11-3-49</u>		REGISTRAR'S SIGNATURE <u>Dorothy Hockman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>363 Clifford H. H. Winda</u>		ADDRESS <u>OWENSVILLE</u>			

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

NOV 29 1949

District File Number _____
District Health Officer No. 9,
NOV 5 1949 RECEIVED

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.

Student
Student Embalmer

Signed Melvin A. W. Weston

Licensed Embalmer No. 3838

P. O. Address Owensville, 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.