

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 35678  
9105

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 5408 S Broadway	
3. NAME OF DECEASED (Type or Print) a. (First) HARIETTA b. (Middle) WALTZ c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 6 1866
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 85
11a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS John W. Hoerr 5408 s Broadway
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident due to  ANTECEDENT CAUSES DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) 93	
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? 331X	
22. I hereby certify that I attended the deceased from Nov. 29, 1949, to Oct. 21, 1949, that I last saw the deceased alive on Oct. 21, 1949, and that death occurred at 4:00 p. m., from the causes and on the date stated above.			
23a. SIGNATURE R. Hoflacker MD (Degree or title)		23b. ADDRESS 11 5400 Arsenal St.	23c. DATE SIGNED 10/22/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-24-49	24c. NAME OF CEMETERY OR CREMATORY Valhalla	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REGISTRAR OCT 24 1949	REGISTRAR'S SIGNATURE J. B. Sarsater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. P. Fendler Jr. 7128 Michigan	

(Licensed Embalmer's Statement on Reverse Side)

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

9105

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 I

Signed Clarence Pochon

Licensed Embalmer No. 3093

P. O. Address 17178 Mich

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.