

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35023**
Registrar's No. **8447**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Moline	
c. LENGTH OF STAY (In this place) 2 wks		d. STREET ADDRESS (If rural, give location) 10187 Imperial Dr.	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) C c. (Last) Landwehr			4. DATE OF DEATH (Month) (Day) (Year) Oct 5th, 1950		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb 11th, 1893	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Henry Landwehr	13b. MOTHER'S MAIDEN NAME Elizabeth Pottif	14. NAME OF HUSBAND OR WIFE Ethel Landwehr
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, state year or date of service) no	16. SOCIAL SECURITY # 494-09-3698	17. INFORMANT'S SIGNATURE OR NAME Ethel Landwehr	ADDRESS 10187 Imperial Dr.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchogenic Carcinoma Rt. Lung 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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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? 162X

22. I hereby certify that I attended the deceased from **9-22**, 19**50**, to **10-5**, 19**50**, that I last saw the deceased alive on **10-4**, 19**50**, and that death occurred at **10:30 a** m., from the causes and on the date stated above.

23a. SIGNATURE H. Schrepel, M.D.	(Name or title)	23b. ADDRESS DePaul Hosp.	23c. DATE SIGNED 10-5-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 10/9/50	24c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. OCT 6 1950	REGISTRAR'S SIGNATURE J. B. Sarator	25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home	ADDRESS 8319 Hallsferry
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4899

P. O. Address St Charles, 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.