

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 6 - 1951

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1003

State File No. 5385

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY-REG. DIST. NO. _____		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri				c. LENGTH OF STAY (in this place) 48		CITY (If outside corporate limits, write RURAL and give township) Richmond Heights		TOWN		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS 1105 Yale				4485		
3. NAME OF DECEASED (Type or Print) FRED		a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) JUNE 11 1951		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb 15, 1886		9. AGE (in years last birthday) 65		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Enfield Ill.		12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Jacob Walter			13b. MOTHER'S MAIDEN NAME Amelia G. Daefner			14. NAME OF HUSBAND OR WIFE Mary A. Walter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary A. Walter				ADDRESS 1105 Yale Richmond Heights	
18. DATE 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) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH		
		ANTECEDENT CAUSES Morbid 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. <u>Parkinsonism</u>								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		491X				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 11						
22. I hereby certify that I attended the deceased from <u>5-27-51</u> , 19 <u>51</u> , to <u>6-11-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>6-11-51</u> , 19 <u>51</u> , and that death occurred at <u>4:10P</u> m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) James D. Hutchinson, M.D.				23b. ADDRESS 1515 Lafayette Avenue			23c. DATE SIGNED 6-12-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-14-51		24c. NAME OF CEMETERY OR CREMATORY Lakewood Ok Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo				
DATE REC'D BY LOCAL REG. JUN 13 1951		REGISTRAR'S SIGNATURE J. B. Kasata			25. FUNERAL DIRECTOR'S SIGNATURE Mollerberg Funeral Home			ADDRESS Webster - Young Mo		

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, ~~only~~ Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Alton R. Rembuis

Licensed Embalmer No. 7283

P. O. Address St. Louis, 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.