

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>6598</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS,</u>			c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ST LOUIS,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>4704 BESSIE COURT</u>				e. STREET ADDRESS (If rural, give location) <u>4704 BESSIE COURT</u> <u>20790</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u> b. (Middle) <u>H.</u> c. (Last) <u>DREYER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 15, 1954</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>12/10/1898</u>	
9. AGE (In years last birthday) <u>55</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MONARCK METALSTRIP CORP.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST LOUIS MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>HERMAN DREYER</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE WALKENFORD</u>		14. NAME OF HUSBAND OR WIFE <u>AGNES DREYER</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>AGNES DREYER 4704 BESSIE COURT</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Prostate</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>metastatic ca to lung</u> DUE TO (c) <u>on bones even skull & brain -</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
19a. DATE OF OPERATION <u>3 years ago</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca Prostate</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <u>X</u>		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? <u>177X</u>			
22. I hereby certify that I attended the deceased from <u>Nov 10, 1953</u> , to <u>7/15, 1954</u> , that I last saw the deceased alive on <u>7/15, 1954</u> , and that death occurred at <u>1:48</u> m., from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>Carl A. Watterberg M.D.</u>				23b. ADDRESS <u>3720 Wash. Ave</u>		23c. DATE SIGNED <u>7/16/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12/19/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>JUL 17 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS. <u>STROOT - CARROLL 4600 NATURAL BRIDGE AVE</u>			

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *M W Ruster*.....

Licensed Embalmer No. *486*.....

P. O. Address *St Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.