

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| BIRTH NO. ....   |  | REG. DIST. NO. <u>317</u>  |  | PRIMARY REG. DIST. NO. <u>500</u>  |  | Registrar's No. <u>1779</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>St. Louis</u> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give TOWN <u>Normandy</u> )  |  | c. LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>  |  | c. CITY <u>VELDA VILLAGE HILLS</u> OR TOWN <u>Normandy</u>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6710 Edison Ave</u>   |  |  |  | STREET ADDRESS (If rural, give location) <u>6710 Edison Ave</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Wilhelmina</u>   |  | b. (Middle) <u>Mary</u>  |  | c. (Last) <u>WALTHER</u>   |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 29, 1955</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>Jan. 29, 1876</u>  |  |
| 9. AGE (In years last birthday) <u>79</u>  |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>  |  | IF UNDER 1 HR. Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</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>Adam Kissner</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Witte</u>  |  | 14. NAME OF HUSBAND OR WIFE <u>Christopher C. Walther</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dr. Adam Walther 6172 Delmar Blvd.</u>  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  |  |  |  | <u>2 days</u>  |  |
|  |  | ANTECEDENT CAUSES  |  |  |  | ?  |  |
|  |  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterial Hypertension</u> |  |  |  | ?  |  |
|  |  | DUE TO (c) <u>High Blood Pressure</u>  |  |  |  | ?  |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS   |  |  |  |  |  |
|  |  | Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |  |  |  |
| 19a. DATE OF OPERATION <u>  </u>   |  | 19b. MAJOR FINDINGS OF OPERATION <u>  </u>   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>  </u>   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>                                       |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>  </u>  |  | 21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  | 21f. HOW DID INJURY OCCUR? <u>  </u>   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>July 28<sup>th</sup>, 1955</u> , to <u>July 29<sup>th</sup>, 1955</u> , that I last saw the deceased alive on <u>July 28<sup>th</sup>, 1955</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <u>U.S. Nichman - M.D.</u>  |  |  |  | 23b. ADDRESS <u>4660 Maryland Ave</u>  |  | 23c. DATE SIGNED <u>July 30<sup>th</sup></u>   |  |
| 24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>Aug. 1, 1955</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>  |  |
| DATE REC'D BY LOCAL REG. <u>8/2/55</u>   |  | REGISTRAR'S SIGNATURE <u>Harvey P. Donike, M.D.</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alexander &amp; Sons 6175 Delmar Blvd</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 *Joe E. McCulloch*.....

Licensed Embalmer No. *246*.....

P. O. Address *6175-D*.....

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.