

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38346**  
Registrar's No. **10383**

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 <b>NEBRASKA</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS, MO</b>	c. LENGTH OF STAY (In this place) <b>2 Months</b>	c. CITY OR TOWN <b>FALLS CITY</b>	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 <b>MISSOURI PACIFIC HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>10, NATIONAL APTS. 8268</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>WALTER</b>	b. (Middle) <b>ALBERT</b>	c. (Last) <b>HELM</b>	NOV	25	1955

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JAN 1, 1898</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AGENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MO PAC RR</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Metropolis, Illinois,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>James Albert Helm</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Edgar</b>	14. NAME OF HUSBAND OR WIFE <b>OLLIE MAY</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ollie May Helm, Falls City, Neb.</b>		ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant Tumor involving lung, brain and ileum, primary site undetermined</b>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____			<b>1 year</b>
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 checked="" type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from **SEPT 21, 1955**, to **Nov 25, 1955**, that I last saw the deceased alive on **Nov 24, 1955**, and that death occurred at **7:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Benjamin H. Ueber, 2. R.</b>	23b. ADDRESS <b>Mo. Pac. Hospital - St. Louis</b>	23c. DATE SIGNED <b>25 Nov. 1955</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11-25-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	24d. LOCATION (City, town, or county) (State) <b>Lancaster, Kansas</b>
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DATE REC'D BY LOCAL REG. <b>NOV 28 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington,</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *J Wm Bentley*.....  
Licensed Embalmer No. *365*  
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.