

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6641**
1829
Registrar's No.

| | | | | | | | | | | | | | |
|---|--|---|--------------------------|--|----------------------------|--|-----------|--|---|---|--|-----------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | 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) OR TOWN ST. LOUIS, MISSOURI | | | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN St. Louis | | 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 ST. LOUIS CITY HOSPITAL #1. | | | | e. STREET ADDRESS (If rural, give location) 4333 Olive Street., | | | | 219 to | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) Walter | | b. (Middle) HIMMLER | | c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) FEB. 17, 1956 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH Dec 2, 1883 | | 9. AGE (In years last birthday) 72 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper - Notary Public Office | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Antonio, Missouri | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME George Himmler | | | | 13b. MOTHER'S MAIDEN NAME Amelia Bockstaller | | | | 14. NAME OF HUSBAND OR WIFE Mamie Himmler | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. Nil | | 17. INFORMANT'S SIGNATURE OR NAME Amelia Dare, 2713 Osage Street., | | | | ADDRESS | | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease Arteriosclerotic heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction Myocardial infarction DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary embolus Pulmonary Embolus. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 420.0 | | | | | | | | 20. AUTOPSY? YES <input checked="" 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) | | | | | | | |
| 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? | | | | | | | | | |
| 22. I hereby certify that I attended the deceased from 1-24 , 19 56 , to 2-17 , 19 56 , that I last saw the deceased alive on 2-17 , 19 56 , and that death occurred at 6:20A m. , from the causes and on the date stated above. | | | | | | | | | | | | | |
| 23. SIGNATURE Martin G. Austin M.D. (Degree or title) | | | | | | 23b. ADDRESS 1515 LAFAYETTE AVE. | | 23c. DATE SIGNED 2-17-56. | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 2-20-56 | | 24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri. | | | | | | | |
| DATE REC'D BY LOCAL REG. FEB 20 1956 | | REGISTRAR'S SIGNATURE Carl Smith MD | | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington | | | | | | | |

(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 *Robert M. Murray*
Licensed Embalmer No. *3749*
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.