

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11246**
Registrar's No. **2495**

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 Missouri b. COUNTY Reynolds	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 4 Days	c. CITY OR TOWN Lesterville
d. FULL NAME OF (If not in hospital or institution, give street address or location) Jewish Hospt.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) _____ c. (Last) Waller		4. DATE OF DEATH (Month) (Day) (Year) March 12 1957	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 5 1897	9. AGE (In years last birthday) Months Days Hours Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (City and State or Foreign Country) Davenport, Iowa	
13a. FATHER'S NAME Jacob Claussen		13b. MOTHER'S MAIDEN NAME Margaretta Mohr	14. NAME OF HUSBAND OR WIFE Frank Waller	

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. Unk.	17. INFORMANT'S SIGNATURE OR NAME Mrs. William Coonrod	ADDRESS 8137 Titus Rd.
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------------------	----------------------------------

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, asphyxia, 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) Acute pulmonary edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease.		
DUE TO (c)		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 **3/10 1957**, to **3/12 1957**, that I last saw the deceased alive on **3/12 1957**, and that death occurred at **2:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Neilny Elderby MD	(Degree or title)	23b. ADDRESS 462 No Taylor	23c. DATE SIGNED 3/12/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-13-57	24c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery	24d. LOCATION (City, town, or county) (State) Davenport, Iowa

DATE REC'D BY LOCAL REG. MAR 13 57	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Clark F.H.	ADDRESS 1125 Hodiamont Ave.
----------------------------------------------	--------------------------------------------------	------------------------------------------------------------	---------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

