

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38422

STATE FILE NUMBER

FILED OCT 28 1957

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2574

Health  
Welfare  
Public  
Service

100  
-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
A. J. Metzger  
2739 N. Grand

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St Louis</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> COUNTY <b>St. Louis</b>                         |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>University City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>University City</b><br>4376<br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1130 Eighty First</b>  |  | Length of stay in 1b<br><b>20 yrs</b>   | d. STREET ADDRESS (If outside, give location) <b>1130 Eighty First</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HELEN</b> Middle <b>WALKER</b> Last   |  |   | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>11</b> Year <b>1957</b>   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Apr 30 1880</b>  |
| 9. AGE (In years last birthday)<br><b>77</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |
| 10a. USUAL OCCUPATION   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Chamola Mo</b>   |
| 13. FATHER'S NAME<br><b>Dennis Glavin</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth ?</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Cornelia Ritter 1130 - 81st St.</b><br>Address  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b>   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sept 23 - 57</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Chronic arteriosclerotic Cardiovascular Dis.</b>  |  |   | <b>3 - 4 yrs</b>  |
| DUE TO (c) <b>4/22/14</b>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of Ascending Colon. (?)</b>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)    | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE  |
| 21. I attended the deceased from <b>Sept 23 1957</b> , to <b>Oct 11 1957</b> and last saw her alive on <b>Oct 10 - 57</b><br>Death occurred at <b>12:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE<br><b>Albert J Metzger md</b> (Degree or title)  | 22b. ADDRESS<br><b>2739 N Grand Blvd</b>   | 22c. DATE SIGNED<br><b>10-12-57</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>10/12/57</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholic Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Chamola Mo</b>  |
| 24. FUNERAL DIRECTOR<br><b>Ortmann F Home 9222 Lackland</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>10-11-57</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Herbert A. Dombek md</b>  |

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 W. C. Ostmann  
Licensed Embalmer No. 347

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.