

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

45778  
STATE FILE NUMBER  
12692

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Parklane Hosp</b>		Length of stay in 1b	d. STREET ADDRESS <b>7078 Lindenwood Pl</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>W</b> Last <b>Dyer</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Ser. Co Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	9. AGE (In years last birthday) <b>68</b> F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>Rolla, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John B. Dyer</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Overlease</b>	
14. NAME OF HUSBAND OR WIFE <b>Nellie M. Dyer</b>		17. INFORMANT Address <b>Nellie M. Dyer 7078 Lindenwood Pl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>World #1</b>		16. SOCIAL SECURITY NO. <b>493-10-8690</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Haemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Essential Hypertension</b> DUE TO (c) <b>331 x H</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Colon &amp; Intestinal Obstruction</b>		19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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>12/22/57</b> to <b>12/31/57</b> and last saw her alive on <b>12/31/57</b> Death occurred at <b>4:05 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Almond Mallets M.D.</b>		22b. ADDRESS <b>607 North Grand St. St. Louis</b>	
22c. DATE SIGNED <b>1/1/58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>12/31/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Rolla, Missouri</b>		24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	
25. DATE RECD. BY LOCAL REG. <b>JAN 2 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith mo</b> <b>m JB</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

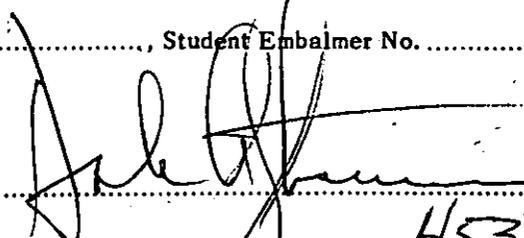
MEDICAL CERTIFICATION

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.

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  .....

Licensed Embalmer No. 4533 .....

P. O. Address .....

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.