

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8786

STATE FILE NUMBER

**FILED SEP 27 1961**

1. PLACE OF DEATH  
 a. COUNTY \_\_\_\_\_  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b \_\_\_\_\_  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE Mo. b. COUNTY \_\_\_\_\_  
 c. CITY OR TOWN St. Louis Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) 4998A LOUGHBOROUGH Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year  
WALTER G DRACH SEPT 19 1961

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 10/25/1887 9. AGE (last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY UNION ELECTRIC 11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME NOT KNOWN 13b. MOTHER'S MAIDEN NAME NOT KNOWN 14. NAME OF HUSBAND OR WIFE IRENE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 17. INFORMANT Address AUDREY TWIEHAUS 20 COVERLY LANE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Cerebral Vascular accident INTERVAL BETWEEN ONSET AND DEATH 4 Days  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cordis Vasculis Disease Chronic  
 DUE TO (c) Arteriosclerosis Generalized Chronic

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Month, Day, Year \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  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 4/18/58 to 9/19/61 and last saw him alive on 9/19/61  
 Death occurred at 3:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Albert H. Cason, M.D. 22b. ADDRESS 4401 Hampton Ave 22c. DATE SIGNED SEP 21 1961

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 9/22/1961 23c. NAME OF CEMETERY OR CREMATORY SUNSET CEMETERY 23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY, Mo.

24. FUNERAL DIRECTOR ADDRESS J. L. ZIEGENHEIN & SONS 7027 GRAVOIS 25. DATE RECD. BY LOCAL REG. SEP 21 1961 26. REGISTRAR'S SIGNATURE Lead Smith, M.D.

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Hawaii

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.