

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8830-61-035029
STATE FILE NUMBER

AMENDED

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

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>15 Min.</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St</u>		c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes # No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>830 No. Kingshighway</u>				Inside Limits Yes # No <input type="checkbox"/>	d. STREET ADDRESS <u>4887 Penrose</u>		Reside on Farm Yes # No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>R.</u> Last <u>WALCHLI</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>22</u> Year <u>1961</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1885</u>	9. AGE (last birthday) <u>76</u>	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) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mercantile</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Walchli</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Hansen</u>			14. NAME OF HUSBAND OR WIFE <u>The Late Nora Walchli</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					17. INFORMANT Address <u>Marvell Carson #40 Lee Ave. Ferguson</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Few Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>MYOCARDITIS</u>					<u>1-YEAR</u>
			DUE TO (c) <u>4222</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ p.m.		Month, Day, Year						
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 <u>June 1, 1941</u> to <u>Sept. 22, 1961</u> and last saw <u>For</u> him alive on <u>Sept. 22, 1961</u>				Death occurred at: <u>3:45 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Martin L. Brockmeier M.D.</u> (Degree or title)				22b. ADDRESS <u>830 N. Kingshighway</u>		22c. DATE SIGNED <u>9/22/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/25/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis County</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann.</u>				25. DATE RECD. BY LOCAL REG. <u>SEP 23 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>		

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann

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.