

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-004701**

STATE FILE NUMBER

Registered on **FILED FEB 7 1962** Primary Registration District No. **1003** Registrar's No. **1294**

AMENDED

1. PLACE OF DEATH a. COUNTY				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>		Length of stay in 1b <b>45 YRS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CHRISTIAN HOSP.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2017 GAND</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DR. AUGUST</b> Middle <b>F.</b> Last <b>WALZ</b>				4. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>1962</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>3-26-1886</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DENTIST</b>		11. BIRTHPLACE (City and state or country) <b>BIG SPRINGS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>CHARLES L. WALZ</b>			13b. MOTHER'S MAIDEN NAME <b>ELIZA JABIN</b>			14. NAME OF HUSBAND OR WIFE <b>CLARA WALZ</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>CLARA WALZ 2017 GAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> DUE TO (b) <b>Kidney Damage due to intubation</b> <b>11 days</b> DUE TO (c) <b>Bil Peritonitis due to Ruptured Gallbladder</b> <b>14 days</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atherosclerotic Cardiovascular Disease</b>						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.) <b>586x</b>					
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 <b>1/17/62</b> to <b>1/28/62</b> and last saw <sup>her</sup> him alive on <b>1/28/62</b> Death occurred at <b>3 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Joseph E. Meyer M.D.</i> (Degree or title)				22b. ADDRESS <b>607 N. Grand Blvd</b>			22c. DATE SIGNED <b>1/29/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>1-31-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO.</b>				
24. FUNERAL DIRECTOR <b>SUED MEYER SONS 3934 N. 20TH ST.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>JAN 30 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Stanley H. Ripon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.