

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULLNAME Walter Samuel Daniels

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Octavia 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased May 11 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 3 26 hr. min.

9. Birthplace Jerseyville Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Baptist Minister

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Walter Scott Daniels  
13. Birthplace Chester Co. Penn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Lena Biehler  
15. Birthplace Switzerland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Octavia Daniels  
(b) Address 3028 Marshall Granite City

17. (a) Removal (b) Date thereof 9-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edwardsville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Ave.

SEP 9 1940 (Date received local registrar) (b) J. J. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County \_\_\_\_\_  
(c) City or town Granite City NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3028 Marshall  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept day 7  
year 1940 hour 6.30 minute 7 M.

21. I hereby certify that I attended the deceased from Aug 30  
1940, to Sept 6 1940;  
that I last saw him alive on Sept 7 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Right pulmonary embolus Duration 12 hrs  
Due to Ca of Caecum 10 mos?  
(ileo-colostomy 9/3/40)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Ca of Caecum 46  
Of operations \_\_\_\_\_ PHYSICIAN  
Of autopsy Pulmonary embolus, M.  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Poland Shepper (M. D. or other) \_\_\_\_\_  
Address 4500 Olive Date signed 9/9/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

79 OCT 25 1940

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Walter G. Hopper*  
Licensed Embalmer No. *2971*  
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 this body is not embalmed, fact should be so stated above.**