2
43
39
35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 2 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13466

State File No.

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 3674

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 54 Hours. (Specify whether
In this community 18 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 615 Westgate Ave
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME FERN M. WALTERS

3. (b) If veteran, name war

3. (c) Social Security No. 307-01-5894

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Fred R. Walters

6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased October (Month) 8th. (Day), 1904 (Year)

8. AGE:

Years	Months	Days	If less than one day
39	6	8	21 hr. 30 min.

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

10. Usual occupation Secretary & Stenographer

11. Industry or business St. Louis Ordnance Depot

FATHER
12. Name Clifford K. Mills
13. Birthplace Palestine (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Lucy Cobb
15. Birthplace Palestine (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Clifford K Mills
(b) Address 8858 N W 5 ave Miami Fla

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21 44 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Palestine, Ill.

18. (a) Signature of funeral director Watson Sorkeage
(b) Address 6536 Clayton Rd.

19. (a) APR 20 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month april day 17
year 1944 hour minute 9:30 P.M.

21. I hereby certify that I attended the deceased from
, 19 , to April 15, 1944
that I last saw her alive on 4-17-44, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus — Duration indefinite

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature Clarence G. Dennis (M. D. ~~or other~~)
Address 1927 [illegible] Date signed 4-19-44

(Licensed Embalmer's Statement on Reverse Side)

Dr Dunn 1927 [illegible]

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 John Ogonoski

Licensed Embalmer No. 3398

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.