

S. No. 2  
OM-5-43  
v. 5-17-39  
1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39196

State File No. \_\_\_\_\_

FILED DEC 2 1946  
378

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

Registrar's No. 9978

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Josephine Heitkamp 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6737 Hoffman Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie Belle Walters

3. (b) If veteran, name war Nil 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louis Walters 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased January 27 1896  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
50 9 23 hr. min.

9. Birthplace Crocker Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Albert Grunise

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Lareg

15. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Walters  
(b) Address 6737 Hoffman Ave.

17. (a) Burial (b) Date thereof 11-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crocker, Missouri  
Albert H. Hoppe

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

19. (a) NOV 22 1946 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20  
year 1946 hour 1 minute 12 P. M.

21. I hereby certify that I attended the deceased from May 1946 to Nov 20 1946  
that I last saw him alive on Nov 20 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock from operation for hydrops of gallbladder  
Due to Gall bladder operation - no stone  
Due to Tertiary Pathological Gall bladder  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 127  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 P. B. Capel M.D. or other \_\_\_\_\_  
Address 3284 Proctor Date signed 11-21

(Licensed Embalmer's Statement on Reverse Side)

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**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 *Henry M. Brammer*

Licensed Embalmer No. *4200*

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.**