. No. 2
-12-45
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

Registration District No. 818

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 11657

Registrar's No. 3061

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(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 Mo (b) County 0-0-0 26 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1940 Dodier 9
(If rural, give location)

(e) Citizen of foreign country? = (Yes or No) 0

If yes, name country =

3. (a) PRINT FULL NAME VERNIE WALTER

3. (b) If veteran, name war =

3. (c) Social Security No. =

4. Sex Fe 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Ed. WALTER WALTER

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

7. Birth date of deceased JULY (Month) 17 (Day) 1877 (Year)

8. AGE: Years 69 Months 8 Days 4 If less than one day hr. min.

9. Birthplace OFALLON (City, town, or county) ILL 1 (State or foreign country)

10. Usual occupation NILL

11. Industry or business =

FATHER
12. Name HY. D. WETMORE 9
13. Birthplace (City, town, or county) UNKNOWN (State or foreign country)

MOTHER
14. Maiden name LUCINDA JAMES 7
15. Birthplace (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant Mr. Ray E. Flint
(b) Address 306 Spring Ave. W. G.

17. (a) Burial Removal (Burial, cremation, or removal) (b) Date thereof 3-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation Shiloh, Ill

18. (a) Signature of funeral director Beiderwieden Funeral Home
(b) Address 1936 St. Louis Ave.

19. (a) MAR 22 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21st year 1947 hour 8:20 minute A M.

21. I hereby certify that I attended the deceased from 3/11/47, 19, to 3/21/47, 19; that I last saw him alive on 3/21/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Jaundice following Malaria

Due to Cleanliness for

Due to Cu of the Cohen

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy As above

Duration

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 0

23. Signature R. Homer (M. D. or other) 3/21/47

Address 1515 Lafayette Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Neal le Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St. Louis Ave

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.