S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 16 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29896

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1721

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7/8/47 to 8/9/47 (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1524 S. 12th St 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME GATERMAN, Walter

3. (b) If veteran, name war WW-1

3. (c) Social Security No. 498099646

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Laura unknown

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

7. Birth date of deceased 2/5/93 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
54	6	4	..... hr. ..... min.

9. Birthplace St Louis, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Hosp Maintenance worker

11. Industry or business .....

FATHER
12. Name unknown 9
13. Birthplace unknown 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Registrar, VAH

(b) Address Jefferson Barracks, Mo

17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof Aug 13-47 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ CALVARY CEM.

18. (a) Signature of funeral director E. J. Schnur Funeral Home

(b) Address 3125 Lafayette St Louis, Mo

19. (a) 8-12-47 (Date received local registrar) (b) [signature] MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th year 1947 hour 7 minute 18 P M.

21. I hereby certify that I attended the deceased from 7/8/47, 19..., to 8/9/47, 19...; that I last saw him alive on 8/9/47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Peripheral Vascular Collapse

Contributory Causes: 1) Carcinoma of ~~xxx~~ Esophagus 2) Pneumonia right middle lobe 3) Atelectasis right ~~xxx~~ base

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations Gastrostomy
Esophagectomy Tracheotomy
Of autopsy None

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) no

(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 ..... (Means of injury)

23. Signature B. J. Owczykowsky (M. D. or other) MD

Address VAH, Jeff, Brks, Mo Date signed 8/9/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

AUG 19 1947

AUG 26 1947

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 Jos R Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette 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.