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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 23 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 34811

Registrar's No. 8830

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community 24 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 3447 LONGFELLOW
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lina Walter

3. (b) If veteran, name war NONE

3. (c) Social Security No.

4. Sex F.

5. Color or race W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased JULY (Month) 23 (Day) 1863 (Year)

8. AGE: Years 85 Months Days 17 If less than one day hr. min.

9. Birthplace BROOKLYN (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name ANTON WALTER
13. Birthplace FRANCE (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name CLARA RHEIN
15. Birthplace GERMANY (City, town, or county) (State or foreign country)

16. (a) Informant E. Z. MORISSE
(b) Address 3447 LONGFELLOW

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-13-48 (Month) (Day) (Year)
(c) Place: burial or cremation BELLEFONTAINE CEM.

18. (a) Signature of funeral director KRIEGSHAUSER
(b) Address 4448 S. KINGSHIGHWAY

19. (a) OCT 11 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10 year 1948 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 9/16/48, 19..., to 10/10/48, 19...; that I last saw her alive on 10/10/48, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Peritonitis	
Due to Mesenteric thrombosis	
Due to Arteriosclerosis, generalized	
Other conditions Carcinomatosis Site not known (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy As above

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 C. L. Vermillion (M. D. or Coroner)
Address Barnes Hospital Date signed 10/11/48

(Licensed Embalmer's Statement on Reverse Side)

NOV 5 1948

NOV 5 1948

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 Richard W. Stovesand

Licensed Embalmer No. 4007

P. O. Address.....

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

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N 07

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8800

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Lina Walters

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 23 (Month) (Day) (Year)

8. AGE: Years 85 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation Housework

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J B Lasater (Registrar's signature) OCT 29 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Day 17 year 1948 hour minute M.

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

	Duration
Immediate cause of death	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-34811