FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35676

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8807

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis

c. LENGTH OF STAY (in this place): 5 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4090 Fillmore

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: N/A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4090 Fillmore

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle):
c. (Last): Walls

4. DATE OF DEATH (Month) 10 (Day) 11 (Year) '49

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: Dec. 19, 1875

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Joseph Hickel

13b. MOTHER'S MAIDEN NAME: Eliz. Ostenschlagerin

14. NAME OF HUSBAND OR WIFE: Samuel E Walls

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Samuel E Walls 4090 Fillmore

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ✓

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. ✓

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: ✓

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): — 93d

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? — 4222

22. *I hereby certify that I attended the deceased from* 8-27, 1949, *to* 10-11-, 1949, *that I last saw the deceased alive on* 10-11-, 1949, *and that death occurred at* 1-P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. N. Gauslosir M.D.

23b. ADDRESS: 3624 Arsenal St.

23c. DATE SIGNED: 10-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/14/49

24c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cem.

24d. LOCATION (City, town, or county) (State): St. Louis Co. Missouri

DATE REC'D BY LOCAL REG.: OCT 13 1949

REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. L. Ziegenhein & Sons 7027 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7027 Grand

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

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