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FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34261
8002

State File No.

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

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|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) 24 3645 Iowa Ave | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 3645 Iowa Ave | | | |

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|------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------|--------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) Mary | b. (Middle) Theresa | c. (Last) Walther | (Month) 8 | (Day) 14 | (Year) 1953 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 2-3-1867 | 9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months Days |
| 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) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |

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|-----------------------------------------|---------------------------------------------------|-------------------------------------------------------------|
| 13a. FATHER'S NAME Peter Schmidt | 13b. MOTHER'S MAIDEN NAME Katherine Nephut | 14. NAME OF HUSBAND OR WIFE John M. Walther Deceased |
|-----------------------------------------|---------------------------------------------------|-------------------------------------------------------------|

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|--------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME John C. Walther | ADDRESS 3645 Iowa Ave |
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| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH Many yrs |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral regurgitation | | |
| | 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 Enteritis Arterio-sclerosis | | 2 wks 10 yrs |

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|------------------------|----------------------------------|-----------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 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) |
| | | 410X |

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|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------|

22. I hereby certify that I attended the deceased from **July 11th, 1953**, to **Aug 14th, 1953**, that I last saw the deceased alive on **Aug 14th, 1953**, and that death occurred at **1:30 P.M.** from the causes and on the date stated above.

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| 23a. SIGNATURE G. M. Schurich, M.D. | (Degree or title) M.D. | 23b. ADDRESS 5182 Rosa Ave | 23c. DATE SIGNED 8-15-53 |
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|----------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 8-17-1953 | 24c. NAME OF CEMETERY OR CREMATORY Our Redeemer Cemetery | 24d. LOCATION (City, town, or county) (State) Afton, Mo. Mo. |
| DATE REC'D BY LOCAL REG. AUG 17 1953 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE G. P. Giegenhein Bros. ADDRESS 6409 Gravois Ave | |

G.P. (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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

J Wm Bantley

Licensed Embalmer No. *365*

P. O. Address *St Louis*

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

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