

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36093

FILED OCT 26 1954

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8665**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 78 4414a Arco Ave.	

3. NAME OF DECEASED (Type or Print) JOSEPH F. WALTER			4. DATE OF DEATH Sept. 21, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 7, 1895		9. AGE (In years last birthday) 59 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 2 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian-St. Louis School of Pharmacy		10b. KIND OF BUSINESS OR INDUSTRY Oran, Mo.		11. BIRTHPLACE (City and State or Foreign Country) Oran, Mo.	

13a. FATHER'S NAME Joseph Walter		13b. MOTHER'S MAIDEN NAME Elizabeth Vonnamin		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes World War 1		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Catherine Burcks 4414a Arco Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHITIS, chronic		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5021	

22. I hereby certify that I attended the deceased from **Sept. 13, 1954**, to **Sept. 21, 1954**, that I last saw the deceased alive on **Sept. 21, 1954**, and that death occurred at **3:45P m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> M. D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED Sept. 21, 54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Sep. 24, 1954		24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
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DATE REC'D BY LOCAL REG. SEP 22 1954		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS KRIEGSHAUSER 4228 S. KINGSHIGHWAY BL.	
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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.....
Signature of Student Embalmer

Signed *Edwin A. McLevenath*.....

Licensed Embalmer No. *302*.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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