

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13114**  
**3319**  
Registrar's No.

FILED MAY 9 1955

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY OR TOWN <b>ST. LOUIS Mo</b>		c. CITY OR TOWN <b>ST. LOUIS 79</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>1946</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ALEXIAN Bros. Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>8526 SKYLINE COURT</b>	
3. NAME OF DECEASED a. (First) <b>WALTER</b> b. (Middle) <b>T.</b> c. (Last) <b>BILL MEIER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 13, 1955</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>DEC. 15 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b> # UNDER 1 YEAR Months Days # UNDER 1 HR. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOSEPH BILLMEIER</b>		13b. MOTHER'S MAIDEN NAME <b>MOLLIE KAUP</b>	
14. NAME OF HUSBAND OR WIFE <b>EDNA BILLMEIER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WAR II</b>	
16. SOCIAL SECURITY NO. <b>494-01-3409</b>		17. INFORMANT'S SIGNATURE OR NAME <b>EDNA BILLMEIER</b> ADDRESS <b>8526 SKYLINE CT.</b>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral vascular accident</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Right Bundle Branch Block</b> DUE TO (c) <b>Black</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>Undetermined</b>	
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? <b>4330</b>	
22. I hereby certify that I attended the deceased from <b>April 12, 1955</b> , to <b>April 13, 1955</b> , that I last saw the deceased alive on <b>April 12, 1955</b> and that death occurred at <b>2:00</b> p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>William F. Williams M.D.</b>		23b. ADDRESS <b>7619a Gray St. St. Louis Mo</b>	23c. DATE SIGNED <b>4-13-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Apr. 15 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PK.</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, Mo</b>
DATE REC'D BY LOCAL REG. <b>APR 14 1955</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thomas Katis 2906 Beavoie</b>	

m. g. b. (Licensed Embalmer's Statement on Reverse Side)

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

10.1  
202-1210

**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 *Leo J. Budde*  
Licensed Embalmer No. *39*  
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.