

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24520**
Registrar's No. **6066**

BIRTH NO. _____ 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		e. STREET ADDRESS (If rural, give location) 3639 Virginia Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Mathilda b. (Middle) Stemmler c. (Last) Walsor		4. DATE OF DEATH (Month) (Day) (Year) 7-12-1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-21-1882
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Matthew Schaefer	
13b. MOTHER'S MAIDEN NAME Julia Schmidt		14. NAME OF HUSBAND OR WIFE William Walsor	
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. No	
17. INFORMANT'S SIGNATURE OR NAME <i>William Walsor</i>		ADDRESS 3639 Virginia Ave	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocarditis - heart failure ANTECEDENT CAUSES DUE TO (b) Myocarditis - acute heart failure DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 4 yrs one week
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19a. DATE OF OPERATION 6/23/55	19b. MAJOR FINDINGS OF OPERATION Ball stones; ventral hernia; umbilical hernia		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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 584X	

22. I hereby certify that I attended the deceased from **June 14, 1955**, to **July 12, 1955**, that I last saw the deceased alive on **July 12, 1955**, and that death occurred at **9:25 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Pierce W. Powers	(Degree or title) M.D.	23b. ADDRESS 634 No. Grand	23c. DATE SIGNED 7/13/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-15-1955	24c. NAME OF CEMETERY OR CREMATORY St. Matthew's Cemetery	24d. LOCATION (City, town, or county) (State) 4260 Bates St. Mo

DATE REC'D BY LOCAL REG. JUL 14 1955	REGISTRAR'S SIGNATURE <i>Charles Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Siegenheim</i>	ADDRESS 6409 Gravois Ave
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
JE 3-8411

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Law M. Simpson*.....

Licensed Embalmer No... 434

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.