

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31621**
77777
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 77777			
1. PLACE OF DEATH a. COUNTY Missouri				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. LENGTH OF STAY (In this place) 5M 14 da		c. CITY OR TOWN St. Louis		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital				e. STREET ADDRESS (If rural, give location) 10 1155 W. Lee Ave.				210 to	
3. NAME OF DECEASED (Type or Print) a. (First) Julia			b. (Middle) _____			c. (Last) Waechter			
4. DATE OF DEATH (Month) (Day) (Year) 9 4 1955			5. SEX Female			6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single			8. DATE OF BIRTH 10/27/1885			9. AGE (In years last birthday) 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME Henry Waechter			13b. MOTHER'S MAIDEN NAME Julia Hohman			
14. NAME OF HUSBAND OR WIFE _____			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____			
17. INFORMANT'S SIGNATURE OR NAME Chronic Hospital, 5600 Arsenal			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.			19. INTERVAL BETWEEN ONSET AND DEATH one week			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coxsackel Vasculant accident.			II. OTHER SIGNIFICANT CONDITIONS Arthritis deformans.			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? _____			
22. I hereby certify that I attended the deceased from 3/21 , 19 55 , to 9/4 , 19 55 , that I last saw the deceased alive on 9/4 , 19 55 , and that death occurred at 4:30A m. , from the causes and on the date stated above.			23a. SIGNATURE George Esker M.D. (Degree or title) ?			23b. ADDRESS 5600 Arsenal			
23c. DATE SIGNED SEP 6 1955			24a. BURIAL, CREMATION, REMOVAL (Specify) removal			24b. DATE 9-7-55			
24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery			24d. LOCATION (City, town, or county) St. Louis Co., Mo.			25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc. ADDRESS 2161 E. Fair Ave.			
DATE REC'D BY LOCAL REG. SEP 6 1955			REGISTRAR'S SIGNATURE J. Carl Smith m.d.			26. (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.....
Signature of Student Embalmer

Signed *John W. Natz*.....
Student Embalmer No.

Licensed Embalmer No. *37*.....
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.