

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023611

FILED JUL 3 1959

Registration District No. 317 Primary Registration District No. 541 STATE FILE NUMBER 7655 Registrar's No. 7655

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		c. CITY OR TOWN <b>Clayton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mrs. 811 Meramec</b>		d. STREET ADDRESS (If outside, give location) <b>811 S. Meramec</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Merker</b> Last <b>Waller</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1868</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>90yrs</b>
11. BIRTHPLACE (City and state or country) <b>Louisville, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Charles F Merker</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Connell</b>	14. NAME OF HUSBAND OR WIFE <b>William S Waller</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. William E. Waller</b>		Address <b>St. Louis 5, Mo. 811 S. Meramec</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2relat</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arteriosclerosis</b>			<b>year</b>
DUE TO (c) <b>Atrial arteriosclerosis</b>			<b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>Dec 20, 1918</b> to <b>June 19, 1959</b> and last saw her alive on <b>6-17-59</b> Death occurred at <b>2100 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ann F. Merker M.D.</b> (Degree or title)		22b. ADDRESS <b>3520 Central - St. Louis 12</b>	22c. DATE SIGNED <b>6/17/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cave Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Louisville, Ky.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>6-20-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Jos E. McCulloch* .....

Licensed Embalmer No. *2460* .....  
P. O. Address *6175 Palm* .....

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.