

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH **59-031133**

FILED VS AUG 31 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2284 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chesterfield		Length of stay in 1b 41 Yrs.	c. CITY OR TOWN Chesterfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wild Horse Creek Road		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Wild Horse Creek Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Anna Middle Margaret Last Walter			4. DATE OF DEATH Month Aug Day 22 Year 1959		
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 5-01	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state, or country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
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13a. FATHER'S NAME John Walter		13b. MOTHER'S MAIDEN NAME Anna Walter		14. NAME OF HUSBAND OR WIFE none	
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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 Address Mary Walter, Chesterfield, Mo.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Sepsis + coma					12 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) Hepatic metastases					3 MD	
DUE TO (c) Caecum of colon					5 MD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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.)				
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year					
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> 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
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21. I attended the deceased from 8-21-59 to Aug 22 59 and last saw her ^{him} alive on Aug 21 1959
Death occurred at 1:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John H. Schrader MD</i> (Degree or title)		22b. ADDRESS <i>355 Francis Place, Ballwin, Mo.</i>		22c. DATE SIGNED <i>8/21/59</i>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-25-59	23c. NAME OF CEMETERY OR CREMATORY Gumbo Cemetery		23d. LOCATION (City, town, or county) Gumbo Mo.		(State)
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24. FUNERAL DIRECTOR Schrader Funeral Home Ballwin Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. 8-24-59	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>	
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Bellewin

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.