

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016067

AMENDED FILED APR 24 1967 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1022 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John</u>	Length of stay in 1b <u>2 1/2 Mos.</u>	c. CITY OR TOWN <u>Rural-Highway 94</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rugh Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>Highway 94</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>F.</u> Last <u>Walter</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-87</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Walter</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Steffan</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Walter</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Bessie Walter Rt 2, St. Charles M</u>		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic hypertensive cardiovascular disease with decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized arteriosclerosis</u>		<u>2 yrs.</u>
	DUE TO (c) <u> </u>		<u> </u>

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"/> N. <input type="checkbox"/> Unknown	
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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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		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	

21. I attended the deceased from 8-1-56 to 4-12-61 and last saw her/him alive on 4-7-61
Death occurred at 12:10 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>634 N. Grand Blvd.</u>		22c. DATE SIGNED <u>4/13/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gumbo Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Gumbo Mo.</u>		23e. (State) <u>Mo.</u>		23f. (State)	
24. FUNERAL DIRECTOR ADDRESS <u>Schrader Funeral Home Ballwin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-13-61</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Richard M. Papp

Licensed Embalmer No. 4584

P. O. Address Ballwin, Mo.

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.