N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D MAR 13 1939

4584
Do not use this space.

791

1. PLACE OF DEATH
(a) County North St. Louis — Registration District No. 1003
(b) Township — Primary Registration District No. — Registered No. 1277
(c) City St. Louis, Mo. — (d) Street No. 220 Talcott St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. — (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 420 Sallie Walls
(a) Residence, No. 220 Talcott St. 9
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Jacob Walls
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unknown
7. AGE: About 64 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House work
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): South Carolina

FATHER
13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): South Carolina

MOTHER
15. MAIDEN NAME: Millie Page
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): South Carolina

17. INFORMANT (ADDRESS): Jacob Walls, 220 Talcott
18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE Feb 9 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Macy Wade, 4202 Finney Ave.
20. FILED FEB 9 1939 J. F. Budeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 6th, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 5th, 1939 to Feb. 6th, 1939
I last saw him alive on Feb. 6th, 1939. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Chronic Myo-Carditis
Acute Gastritis

Other contributory causes of importance:
Chronic Rheumatism
Eating a pork sandwich caused
Ptomaine Poisoning

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury 2-5, 1939
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) J. E. Hurt, M. D.
(Address) 923 N. Jefferson

(Licensed Embalmer's Statement on Reverse Side)

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

Registered Apprentice No. ——, working under my personal supervision.

Signed S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 chanter

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.