

350 APR 12 1939

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

791
1008

9266
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City. St. Louis, Mo (d) Street No. City Sanitarium St. 3031
(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 69 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Henry Wallace

(a) Residence, No. City Infirmery St. 13 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 74 - - -

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. NIL
9. Industry or business in which work was done, as saw mill, bank, etc. NIL
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) Unknown
Kentucky

FATHER 13. NAME Oliver Wallace

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
Kentucky

MOTHER 15. MAIDEN NAME Lucinda Nunn

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
Kentucky

17. INFORMANT John B. Varner, M.D.
(ADDRESS) 5400 Arsenal

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington DATE 3/10/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. Risher 3500 Ruff
MAR 31 1939

20. FILED..... 19.....
J. B. Buelch
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 5/39 19.....

22. I HEREBY CERTIFY, That I attended deceased from 7-1-38, 19....., to 3-5-39, 19.....
I last saw him alive on 3-5-39, 19..... Death is said to have occurred on the date stated above, at 11:34 A.M.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage, right
17-39
Other contributory causes of importance:
Hypertensive Heart Disease 1936x
Senility 1936x

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
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 John B. Varner, M. D.
(Signed) John B. Varner
(Address) City Sanitarium

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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