S. No. 2
M—5-42
5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4089

Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 11206

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Hrs (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 0011

(a) State Missouri (b) County 17

(c) City or town St. Louis 9 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2748 Gamble Street
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Fontella Wallace

3. (b) If veteran, name war No

3. (c) Social Security No. Unk

4. Sex Fem

5. Color or race 3 Col

6. (a) Single, widowed, married, divorced 1 Married

6. (b) Name of husband or wife Clarence Wallace

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased January 12, 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
39	11	1	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Short order Cook

11. Industry or business Restruant

FATHER
12. Name Amos Williams
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillie Griswald
15. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Clarence Wallace
(b) Address 2748 Gamble Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/43 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Cem

18. (a) Signature of funeral director R. M. C. Green
(b) Address 3517 Laclede Avenue

19. (a) DEC 16 (Date received local registrar) (b) S. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13th
year 1943 hour 4:14 minute A. M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to 108	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury:

23. Signature Alfred Perry (M.D. or other)
Address Cupertino Date signed 12/16/43

(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. P. M. Green

Licensed Embalmer No. 1173

P. O. Address 3517 Locke ave

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, fact should be so stated above.