

FILED JUL 8 1944 318

Primary Registration District No. 1003

Registrar's No. 5784

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-22-44 to 6-23-44
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2675 Lucas
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charlie Walls

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color of race Col White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Sapertha 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 11 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>3</u>	<u>12</u>	hr. _____ min. _____

9. Birthplace Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Shipping Clerk

11. Industry or business _____

12. Name Albert Wall

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Mary J. Buchanan

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Bernilla Buchanan

(b) Address Isolation Hospital

17. (a) Burial (b) Date thereof 6 30 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director A. B. Beal

(b) Address 27 26 Lucy Ave

19. (a) JUN 28 1944 (Date received local registrar) J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1944 hour 5 minute 50 A. M.

21. I hereby certify that I attended the deceased from May 22 1944 to June 23 1944
that I last saw him alive on June 23 1944
and that death occurred on the day and hour stated above.

Immediate cause of death Tuberculosis Far Advanced

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy Far Advanced Bilateral Pulmonary Tbc

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? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature W. K. Klingberg (M. D. or other) _____

Address 5600 Arsenal Date signed 6/23/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *J. Richardson*
Licensed Embalmer No. *2928*
P. O. Address *City*

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.