

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15293**
Registrar's No. **3564**

FILED APR 24 1946
724674
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether)

In this community 10 YEARS
years, months or days)

3. (a) PRINT FULL NAME DAN WALLACE

3. (b) If veteran, name war NINE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

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

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

7. Birth date of deceased NOVEMBER 11 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>5</u>	<u>6</u>	hr. min.

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

10. Usual occupation UNKNOWN

11. Industry or business.....

MOTHER FATHER

12. Name UNKNOWN

13. Birthplace UNKNOWN 4
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN 1
(City, town, or county) (State or foreign country)

15. Birthplace UNKNOWN 0
(City, town, or county) (State or foreign country)

16. (a) Informant City Hospital Records 1

(b) Address 1515 Lafayette St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 19, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Ave.

19. (a) APR 18 1946 J. F. Bredeek
(Date received) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County.....

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 1318 ST. LOUIS AVE.
Memorial (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th
year 1946 hour 4:00 minute A M.

21. I hereby certify that I attended the deceased from 4/2/46
....., 19....., to 4/17/46, 19.....
that I last saw him alive on 4/17/46, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary artery thrombosis
gen arteriosclerosis

Due to.....

Due to.....

Other conditions ///
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy Same

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?

While at work?..... (Specify type of place)
(e) Means of injury 0

23. Signature 1515 Moffatt 4/17/46
(Date received) (Date signed)

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..... *Guy W. Wilkinson*
Licensed Embalmer No. *3575*
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, fact should be so stated above.