

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED DEC 31 1948  
Registration District No. 317

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2765

Primary Registration District No. 3063

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

16  
2  
3

1. PLACE OF DEATH:

(a) County St. Louis County  
 (b) City or town Clayton, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis Co. Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
 (Specify whether years, months or days) 12 yrs.

3. (a) PRINT FULL NAME Joseph D. Wallace  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Wht  
 6. (a) Single, widowed, married, divorced M.  
 6. (b) Name of husband or wife Nancy Farley  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 81 - 9 - 1880  
 (Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 19  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation odd jobs

11. Industry or business \_\_\_\_\_

12. Name do not know

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Hospital Records

(b) Address St. Louis Co. Hosp.

17. (a) Burial (b) Date thereof 12-2-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Cem.

18. (a) Signature of funeral director Ortman's Home  
 (b) Address 222 Lockland Overland Mo

19. (a) 11-30-48 (b) Thurmond  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town Overland  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2307 Woodson  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28th  
 year 1948 hour 5 minute 50 a.m.

21. I hereby certify that I attended the deceased from Nov. 25th, 1948, to Nov. 28, 1948  
 that I last saw him alive on Nov. 28th, 1948,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Secondary to cerebral thrombosis

Due to Arteriosclerotic heart disease

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

Signature H. W. Miller (M. D. or other) \_\_\_\_\_

Address 1012 Brentwood, Clayton Mo. Date signed 11/29/48

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

04 11 1937

**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..... *A. C. Ortman* .....

Licensed Embalmer No..... *3478* .....

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.**