

No. 300
10-48

FILED APR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10793
2816
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Mr. 179

1. PLACE OF DEATH a. COUNTY <u>St. Louis-Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Ill</u> b. COUNTY <u>979</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u> 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chicago</u> 11 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>34 90ak St</u> 2	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Wallace</u> c. (Last) <u>Wallace</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 25, 1949</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Unknown</u>	8. DATE OF BIRTH <u>Aug 1 1906</u>	9. AGE (In years last birthday) <u>42</u>	IF UNDER 1 YEAR Days <u>7</u>	IF UNDER 12 HRS. Hours <u>24</u>	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Miss</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>John Wallace Sr</u>	13b. MOTHER'S MAIDEN NAME <u>Hattie Hunter</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Hattie McCulloch</u> ADDRESS <u>321 Spring</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Heart Disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mild Cardiac Failure and Hypertensive</u> DUE TO (c) <u>Encephalopathy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		93d	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>H/A/O/N</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-18, 1949, to 3-25, 1949, that I last saw the deceased alive on 3-25, 1949, and that death occurred at 6:25 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Oscear L Daniels</u> M. D. <u>U</u>	23b. ADDRESS <u>2601 N Whittier St</u>	23c. DATE SIGNED <u>3-28-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3/29/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chicago Ill</u>	24d. LOCATION (City, town, or county) (State) <u>Chicago Ill</u>
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DATE REC'D BY LOCAL REG. <u>MAR 29 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Hughes</u> ADDRESS <u>2620 Lawton</u>
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... *Clayton Young*

Signed.....
Student Embalmer

Licensed Embalmer No. *33718*

P. O. Address *St. Louis*

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.