

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26450

State File No. ....

FILED JUL 31 1957 REG. DIST. NO. 218 PRIMARY REG. DIST. NO. 1002 Registrar's No. 7011

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>5 days</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> 2183	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>4019 Clayton</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>William</b> c. (Last) <b>Wallace</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7-20-57</b>		
5. SEX <b>mo</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>m</b>	8. DATE OF BIRTH <b>May 23, 1915</b>	9. AGE (In years last birthday) <b>37</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Advance, Mo. D</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					

13a. FATHER'S NAME <b>John R. Wallace</b>		13b. MOTHER'S MAIDEN NAME <b>Melinda Bridgeman</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Myrtle McCormick, Kennett, Mo.</b>	

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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Congestive Heart Failure</b>			DUE TO (b) <b>Severe Rheumatic Heart Disease</b>			6 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)	
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? <b>416X</b>	

22. I hereby certify that I attended the deceased from **7-15**, 19**57** to **7-20**, 19**57** and that death occurred at **2:31** a.m., from the causes and on the date stated above. **7/21/57**

23a. SIGNATURE (Degree or title) <b>FR Bradley MD U</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>7-20-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Kennett, Mo.</b>	

DATE REC'D BY LOCAL REG. <b>JUL 21 1957</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 13 1952

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.....

.....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed *John J. Haines*  
Student Embalmer No. ....  
Licensed Embalmer No. *4108*  
P. O. Address *St Louis, Mo*

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.