

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 30 1956

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State File No. 14950
Registrar's No. 3796

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>ST CLAIR</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>LEBANON</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>8120 S</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>R.</u> c. (Last) <u>Wallace</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 16, 1956</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>AUG. 8, 1895</u>	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Conditioning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scott Air Base</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>LEBANON ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John WALLACE</u>			13b. MOTHER'S MAIDEN NAME <u>KATHERINE BAUM</u>		14. NAME OF HUSBAND OR WIFE <u>Kay Wallace</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY (If yes, give way or date of service) <u>W.W.I & II</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs John Wallace</u>		ADDRESS <u>Lebanon Ill</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Monocytic Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sev. Wks.</u>
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>204.2</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Apr. 11, 1956</u> , to <u>April 16, 1956</u> , that I last saw the deceased alive on <u>April 16, 1956</u> , and that death occurred at <u>1:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E. D. Vermillion M.D.</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>4/16/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>4-17-56</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Lebanon Illinois</u>	
DATE REC'D BY LOCAL REG. <u>APR 17 1956</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>O. Meyer</u>		ADDRESS <u>Lebanon Ill</u>	

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..

Student.....
Signature of Student Embalmer

Signed *Frank Brown*.....

Licensed Embalmer No. *43*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.