

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 29 1956

22185
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **5778**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Faulkner	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Conway 8030	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS 1917 Caldwell	
Length of stay in 1b 12 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Johnnie Donaghey Wallace			4. DATE OF DEATH June 18, 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1911	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY College	11. BIRTHPLACE (City and state or country) Conway, Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Wallace			14. MOTHER'S MAIDEN NAME Nancy Dungan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Ruth Siesicki, Little Rock, Ark.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fibro Sarcoma of Uterus with metastases to brain		INTERVAL BETWEEN ONSET AND DEATH 9 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		174x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **June 6, 1956** to **June 18, 1956** and last saw **her** alive on **June 18, 1956**
Death occurred at **9:00 A.M.** in on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. D. Vanillion, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/18/56
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-18-56	23c. NAME OF CEMETERY OR CREMATORY Oakgrove Cemetery	23d. LOCATION (City, town, or county) (State) Conway, Ark.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. JUN 18 1956	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1956 AUG 8

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, ~~by~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *E. J. Renwick*.....

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.