Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 38293

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9380

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 16 Mo. Baptist Hosp. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis 2039 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3 5976 So. Cuba Ct. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last WALL

4. DATE OF DEATH Month Oct. Day 7 Year 1957

5. SEX Male 0

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sep. 4, 1891

9. AGE (In years last birthday) 66 — 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) Accountant-Wabash

10b. KIND OF BUSINESS OR INDUSTRY R.R. Co.

11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrence Wall

14. MOTHER'S MAIDEN NAME Nora Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 1

16. SOCIAL SECURITY NO. None

17. INFORMANT Address (Wife) Catherine Wall 5976 So. Cuba Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ 420.1
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 ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2-2-56, to 10-7-57 and last saw ~~her~~ him alive on 10-7-57
Death occurred at 3:20 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Herman Bailey MD 0

22b. ADDRESS Mo Theatre Bldg #1114 St Louis 3 Mo

22c. DATE SIGNED 10-8-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Oct.9,1957

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S.Kingshighway

25. DATE RECD. BY LOCAL REG. OCT 8 '57

26. REGISTRAR'S SIGNATURE J Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 45

P. O. Address .....

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