

Health,  
Welfare  
Public  
Service

XC-19 313 957  
SL 16182

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020050  
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5687

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MASSAC</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N. GRAND, ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>METROPOLIS</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL 0</b>		Length of stay in 1b <b>81 days</b>	
d. STREET ADDRESS <b>416 E. 3rd St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALLACE H. PREVALLET</b>			4. DATE OF DEATH Month Day Year <b>JUNE 1, 1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/03</b>
9. AGE (In years last birthday) <b>54</b>	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCERY SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>PERRYVILLE, MO. 0</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>JOSEPH C. PREVALLET</b>		13b. MOTHER'S MAIDEN NAME <b>JULIA SCHNINDLER</b>	14. NAME OF HUSBAND OR WIFE <b>IMOGENE PREVALLET</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-2</b>		16. SOCIAL SECURITY NO. <b>349-10-3479</b>	17. INFORMANT Address <b>VA HOS P. RECORDS, ST. LOUIS, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>RENAL SHUTDOWN AND GENERALIZED HEMORRHAGE</b>			<b>UNKNOWN</b>
DUE TO (c) <b>HODGKINS DISEASE</b>			<b>UNKNOWN</b>
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"/> AT HOME <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. attended the deceased from <b>3/12/58</b> , to <b>6/1/58</b> and last saw <del>him</del> <sup>her</sup> alive on <b>6/1/58</b> Death occurred at <b>1:10 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Victor Paul Johnson M.D.</b>		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>6/1/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Metropolis, Illinois.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 2 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b> <b>m8B</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John S Denne* .....

Licensed Embalmer No. *4194*

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.