ealth,
Welfare
ublic
ervice

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042390
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11168

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 27 Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2119 4218 Maffitt — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Carla Middle Denise Last Wallace
4. DATE OF DEATH Month 11 Day 18 Year 58
5. SEX Fem. 3
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐
8. DATE OF BIRTH 11-17-58
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 13 Min. 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Saint Louis, Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA.
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME Norma Jean Wallace
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records Address 2601 N. Whittier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Premature birth, Neonatal death
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 773.5
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 11-17-58, to 11-18-58 and last saw her alive on 11-18-58
Death occurred at 7:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Park J. White, M. D. 0
22b. ADDRESS 2601 N. Whittier
22c. DATE SIGNED 11-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 11-29-58
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Aker ADDRESS 4104 Manchester
25. DATE RECD. BY LOCAL REG. NOV 20 '58
26. REGISTRAR'S SIGNATURE Earl Smith MD MDB.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address .....

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.