WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22366

1. PLACE OF DEATH

County .... Registration District No. 7911 .... File No. ....

Township .... Primary Registration District No. 6005 .... Registered No. 6555

City St Louis (No. 2246 Dolier St .... St. .... Ward)

2. FULL NAME Henry Wallis

(a) Residence. No. 2246 Dolier St., 20 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ...... yrs. ...... mos. ...... ds. How long in U.S., if of foreign birth? ...... yrs. ...... mos. ...... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(or) WIFE OF~~ Elizabeth Wallis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 21, 1857

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ......min.
71	3	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer ....

9. BIRTHPLACE (CITY OR TOWN) ....
(STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER August Wallis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ....
(STATE OR COUNTRY) Germany

14. INFORMANT Elizabeth Wallis
(Address) 2246 Dolier St

15. FILED JUN 22 1928 Max C Starkloff Jr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

Found dead

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1928

17. I HEREBY CERTIFY, That I attended deceased from ...., 19......, to ...., 19......

that I last saw h...... alive on ...., 19......, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxiation due to Illuminating Gas Poison While Suffering from temporary Mental Aberration (duration) ...... yrs. ...... mos. ...... ds.

CONTRIBUTORY (SECONDARY) Suicide ...... mos. ...... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) J. W. Dennie, M.D.

6/22 1928 (Address) Dep. Coron

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Memorial Park Cemetery

DATE OF BURIAL: June 23 1928

20. UNDERTAKER: Diekmann Harral

ADDRESS: 1905 Union