

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

Do not use this space.

19959

File No. \_\_\_\_\_  
Registered No. **5601**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. **701**  
Township \_\_\_\_\_ Primary Registration District No. **003**  
City **St. Louis** (No. **Deaconess Hospital**)

**2. FULL NAME**

(a) Residence No. **5217 Conde** St. **9** 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 <b>Male</b>		4. COLOR OR RACE <b>White</b>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Married</b>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>March 15 - 1898</b>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
	<b>34</b>	<b>2</b>	<b>3</b>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work. <b>Salesman</b>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
(c) Name of employer <b>Lilly-Williams Paper Co</b>					
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>St. Louis Mo</b>					
PARENTS	10. NAME OF FATHER <b>James Wallace</b>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <b>unknown</b>				
	12. MAIDEN NAME OF MOTHER <b>Kate Stotter</b>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <b>unknown</b>				
14. INFORMANT <b>Mrs. Lillie Wallace</b> (Address) <b>5217 Conde St.</b>					
15. FILED <b>MAY 21 1929</b> <b>W. C. Stotter</b> REGISTRAR					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 18 1929**  
17. I HEREBY CERTIFY, That I attended deceased from **April 21**, 1929, to **May 18**, 1929, that I last saw him alive on **May 18**, 1929, and that death occurred, on the date stated above, at **4:30 P.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Acute Lymphoid Leukemia**

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, Residence \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? **no** DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Laboratory Exam of blood.**  
(Signed) **Ben de Bull**, M. D.

**5-20, 1929** (Address) **6104 Easton Ave.**

\*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 DATE OF BURIAL

**St. Peter's Cemetery** **May 21 1929**

20. UNDERTAKER ADDRESS

**Wm. Schmader** **4834 N. Bridge**

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.

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20 Dec 1952