

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

Do not use this space.

17985

1. PLACE OF DEATH

County..... Registration District No. 701
 Township..... Primary Registration District No. 1003
 City St. Louis (No. **ISOLATION HOSPITAL** Ward) 24

2. FULL NAME

Cleve Wallace
 (a) Residence No. 3028 Lucas, 21 Ward. (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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
abt. 37 ? Unknown

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

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Louise Turner
 (Address) ISOLATION HOSPITAL

15. MAY 26 1930 FILED W. C. Starnes
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 19 30

17. I HEREBY CERTIFY, That I attended deceased from May 10, 19 30, to May 19, 19 30 that I last saw him alive on May 19, 19 30 and that death occurred, on the date stated above, at 8:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis, meningococci
18 (duration) yrs. mos. 11 ds.

CONTRIBUTORY (SECONDARY) 24 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. C. Starnes, M. D.

5-19, 19 30 (Address) **ISOLATION HOSPITAL**

*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
Father Dixon Cem. May 26 19 30

20. UNDERTAKER ADDRESS 1003
Bruce and Rowlett Harrison

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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ADP 10

Handwritten signature or scribble