

SEP 25 1935

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

Do not use this space.

27534

1. PLACE OF DEATH

County St. Louis

Township

City ClaytonRegistration District No. 790Primary Registration District No. 6033A(No. 7734 Bonhomme Avenue)

File No.

Registered No. 232

St. Ward

2. FULL NAME Jennie L. Wallace(a) Residence, No. 7734 Bonhomme Avenue St. 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

Female

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

Joseph C. Wallace

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

Unknown 04.80

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Manchester Missouri

13. NAME of Father

q Austin Massey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

West Virginia

15. MAIDEN NAME

Unavailable

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unavailable

17. INFORMANT

(ADDRESS)

Joseph C. Wallace 7734 Bonhomme Avenue,

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Maplewood 04 Aug. 1935

19. UNDERTAKER

(ADDRESS)

Charles J. Tate 4107 Finney Avenue

20. FILED

871935 09 25 J. J. Signorelli Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 4th, 1935I HEREBY CERTIFY, That I attended deceased from July 18, 1935 to August 4th, 1935I last saw her alive on August 4th, 1935 Death is saidto have occurred on the date stated above, at 10:45m. A.M.

The principal cause of death and related causes of importance were as follows:

Myocarditis Chron

Other contributory causes of importance

Nephritis Acute 7/5

Name of operation

What test confirmed diagnosis?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

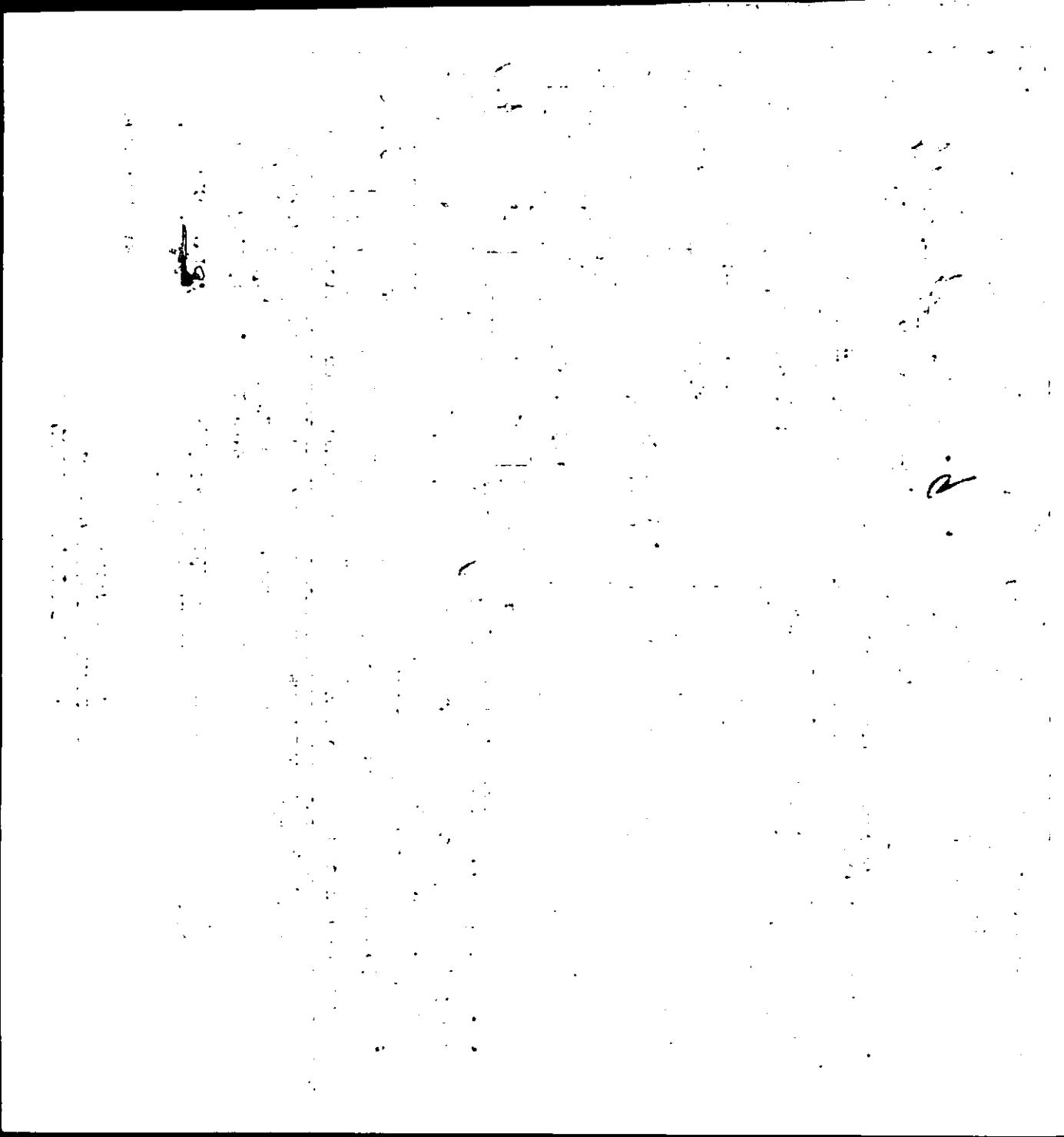
Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify

(Signed) James E. Stefford, M. D.(Address) 925 North Jefferson Avenue



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY CARD. Do not use this space.

1. PLACE OF DEATH

County St. Louis
Township Clayton
City Clayton (No. _____)

Registration District No. 790
Primary Registration District No. 6033A

File No. _____
Registered No. 232
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) un

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 55

7. AGE YEARS MONTHS DAYS If less than 1 day, _____ hrs. _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____
10. Date when last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 10/24 1935 A. Hignorella Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4, 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Date of onset _____

No further history
Other contributory causes of importance:
Septic infection of the foot - organ?
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) James Stafford, M. D.
(Address) _____

OCT 19 1935

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