WHITE 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.

85 APR 12 1939

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

791
1003

8539
Do not use this space.
2304

1. PLACE OF DEATH

(a) County ..... Registration District No. 2 1

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) or City St. Louis, Mo. (d) Street No. 1102 Chambers St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME Marie Walls.

(a) Residence, No. 1102 Chambers St. St. 26
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female.	White.	Married.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 26, 1892.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
47.	1	11	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as saw mill, bank, etc. At Home.
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) Iowa.

FATHER
13. NAME William Nailer.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER
15. MAIDEN NAME Eva Morrison.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa.

17. INFORMANT (ADDRESS) Samuel Walls. 1102 Chambers St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Friedens. DATE March 11, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Math Hermann & Son. 2161 East Fair Ave.

20. FILED MAR 11 1939 J. F. Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March. 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 3, 1939, to March 9, 1939
I last saw her alive on March 9, 1939. Death is said to have occurred on the date stated above, at 9.08 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	3/4/39

Other contributory causes of importance:

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 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? .....
If so, specify .....
(Signed) James T. Cook, M. D.
(Address) 5536 Robin Ave

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Leonard Hampton

Licensed Embalmer No. 2967

P. O. Address 2161 C. Fair Av

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.