

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.

REC'D AUG 11 1939

791
1008

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether _____)
In this community 35 years
years, months or days)

3. (a) PRINT FULL NAME Samuel Wallace. 420

3. (b) If veteran, name war none 3. (c) Social Security No. unknown

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Katherine C. Wallace. 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased Jan'y, 10, 1874.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65. 5. 26. _____ hr. _____ min.

9. Birthplace County Antrim, Ireland. 5
(City, town, or county) (State or foreign country)

10. Usual occupation Retired, connected with 8

11. Industry or business Carlton D. G. Co. 9

MOTHER FATHER { 12. Name William Wallace. 9

13. Birthplace County Antrim, Ireland.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Stuart.

15. Birthplace County Antrim, Ireland.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Helas McKinley

(b) Address Country Club Grounds.

17. (a) Burial. (b) Date thereof -7-8-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar Blv'd.

19. (a) JUL 6 1939 (b) J. B. Reddick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. 1 (b) County _____
(c) City or town St. Louis, 10
(If outside city or town limits, write "RURAL")
(d) Street No. 4552 Ashland, Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th
year 1939 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from second
1938 to July 5th 1939
that I last saw him alive on July 5th 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Heart
attack

Duration
15 mos.

Due to _____

Due to _____

Other conditions Sub normal over anemia 6 mos.
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
(e) Means of injury _____

23. Signature Dolan Ramsey (M. D. or other)

Address 508 N. Kimmel Date signed 7/6/39

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~~.....

Clarence H Murray

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Clarence H Murray

Licensed Embalmer No.

4011

P. O. Address.....

St Louis

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

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