

Registration District No. **791**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:** FILED MAR 12 1940  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **Enroute City Hospital**  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town **St. Louis, Mo.**  
(d) Street No. **4257a Hunt Ave.**  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** **Samuel H. Wallace**  
**420**  
(b) If veteran, name war No. \_\_\_\_\_  
3. (c) Social Security No. **489-10-4588**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Feb.** day **5th**  
year **1940** hour **1:25** minute **P.** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Lora** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 27 1892**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;**  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>47</b>	<b>9</b>	<b>8</b>	hr. _____ min. _____

Immediate cause of death **Lysol Poisoning; self administered, at his home, February 5, 1940, about 1:25 P.M.**

9. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other condition \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation **Tobacco Worker**  
11. Industry or business **Liggett-Myers Tob. Co.**

Major findings \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**MOTHER FATHER**  
12. Name **Henry Wallace**  
13. Birthplace **Unknown**  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant **William Wallace**  
(b) Address **Rock Island, Ill.**  
17. (a) **Burial** (b) Date thereof **2-9-40**  
(c) Place: burial or cremation **Valhalla Cemetery**

**22. If death was due to external causes, fill in the following:**  
(a) Accident, suicide, or homicide (specify) **Suicide**  
(b) Date of occurrence **February 5, 1940**  
(c) Where did injury occur? **St. Louis, Mo.**  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **In Home**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Ave.**  
19. (a) **FEB 8 1940** (b) **J. F. Brubaker**

23. Signature **W. J. Perry** (M. D. or other)  
Address **1014 E. Chestnut** Date signed **2-7-40**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

**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.....

*Guy W Wilkinson*

Licensed Embalmer No. 3575

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4458  
Registrar's No. 1288

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Samuel H Wallace

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race wh 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) APR 3 1940 (b) J. F. Budach (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month 2 day 2 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

