

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9402  
Registrar's No. 2885

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital #1  
(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)

3. (a) PRINT FULL NAME George W. Wall

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

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

6. (b) Name of husband or wife Ida Wall 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Abt. 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Abt. 70 Unknown hr. \_\_\_\_\_ min.

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

10. Usual occupation Clerk

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

MOTHER FATHER { 12. Name George Wall 210 W  
13. Birthplace Unknown 219  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Wall  
(b) Address 1749a Dolman

17. (a) Burial (b) Date thereof 3/30/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director C. Maydell  
(b) Address 1926 Allen, Ave.

19. (a) MAR 28 1940 (b) J. H. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 23  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1749a Dolman, St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 27  
year 1940 hour 10 minute 10 AM

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 Fracture of right leg bones  
Peritonitis

Due to Peritonitis

when struck with rod

Due to rod

by Alvin [Name]

Other conditions (Include pregnancy within 3 months of death)  
Californian and Russell

Major findings of organs about 6:40 P.M. March 11-1940

Of autopsy Accident

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 3/11/40

(c) Where did injury occur? St. Louis  
(City or town) (County) (State)

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

(e) Means of Injury rod  
While at work (Specify type of place) (f) Means of Injury

23. Signature Joseph [Signature]  
Address Deputy Coroner

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.....

*Benj. C. Duncan*

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

**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.**