

No. 2  
1-10-39  
1-1-42

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

13202

State File No.

3404

Registration District No. 791

Primary Registration District No.

Registrar's No.

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: City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hrs  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME George B. Wallace

3. (b) If veteran, name war 770 3. (c) Social Security No. 770

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

6. (b) Name of husband or wife Lucille 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Oct 22 1904  
(Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 28 If less than one day hr. min.

9: Birthplace Washington Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business

12: Name George B. Wallace

18. Birthplace Indiana  
(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 Mrs. Lucille Wallace

(b) Address 1533 So Broadway

17. (a) Burial (b) Date thereof 4-15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem

18: (a) Signature of funeral director W. J. Wagoner

(b) Address 4016 Chippewa St

19. (a) APR 15 1940 (b) [Signature]  
(Date of death) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 23  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1533 South Broadway  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th  
year 1940 hour 5:15 minute A. 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 Subsidiary  
absciss of Lung  
(Circ Tubercular)  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: 14/16

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?

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Signature] Date signed 4-15-40

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

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

*Ernest W. Spillars*

Licensed Embalmer No.

*4080*

P. O. Address

*3528 Russell Rd*

**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.**