FILED JUN 1 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1948

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1002

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton 9
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7307 Northmoore Drive
(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 Missouri (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 7307 Northmoore Dr.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Corinne Wall 400
3. (b) If veteran, name war
3. (c) Social Security No. 492-00-8368
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 22 (Day) -1899 (Year)

8. AGE: Years 40 Months 6 Days 1 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Charles J. Wall
13. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Mollie Hyman
15. Birthplace (City, town, or county) Tennessee (State or foreign country)
16. (a) Informant Alfred Hirsch
(b) Address 7303 Northmoore
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery
18. (a) Signature of funeral director [signature]
(b) Address 5216 Delmar
19. (a) MAY 24 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23rd year 1940 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 14, 1932, to May 23, 1940, that I last saw her alive on May 22, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular heart disease (Mitral Stenosis) — Duration 8 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 92

Major findings: Of operations

Of autopsy

PHYSICIAN — 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? (Specify type of place)
(e) Means of injury
While at work
23. Signature Solom Cameron (M. D. or other)
Address 5087 Bragaw Date signed 5/24/40

(Licensed Embalmer's Statement on Reverse Side) CAMERON

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 Chas W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Delmar

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

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

. No. 2B
—2-21-40
I X22659

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

F0 5438

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19487

Registration District No. 784 Primary Registration District No. 101 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(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 Corrine Wall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 40 Months 6 Days 1 If less than one day hr. min.

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

10. Usual occupation Book [illegible]

11. Industry or business Laclede Gas Co.

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1940 hour minute M.

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

Immediate cause of death Chronic Valvulus
Heart disease
mitral stenosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

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

23. Signature Solomon Cameron (M.D. or other)
Address 508 N Grand Date signed

S-19487