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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33943

State File No. 8640

Registration District No. 791 Primary Registration District No. 1003 Registrar's 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 5 days (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis 5
(If outside city or town limits, write "RURAL")

(d) Street No. 6244 Pershing
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 74 years.

3. (a) PRINT FULL NAME JOSEPH T. WALL

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased November (Month) 5 (Day) 1859 (Year)

8. AGE: Years 80 Months 11 Days 13 If less than one day hr. min.

9. Birthplace (City, town, or county) England (State or foreign country) 4

10. Usual occupation Ret'd. 4

11. Industry or business Express business 4

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

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

16. (a) Informant Anna M. Wall
(b) Address 6244 Pershing

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/21/40 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Alexander & Sons
(b) Address 6175 Delmar Blvd.

19. (a) OCT 20 1940 (Date received local registrar) (b) J. F. Ordish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18th
year 1940 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from May 1936
, 19 , to Oct 18th , 1940
that I last saw him alive on Oct 18th , 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Senility

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 Frank L Davis (M. D. or other)
Address University Club Bldg Date signed 10/19/40

(Licensed Embalmer's Statement on Reverse Side)

Univ. Clut Bldg,
Dr Frank L. Davis.

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 J. Wm Binkley

Licensed Embalmer No. 3653

P. O. Address St. Louis. Mo

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

6175 Delmar

If this body is not embalmed, fact should be so stated above.