DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12931

FILED MAY 14 1943

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 8246

1. PLACE OF DEATH:

(a) County

(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: Homer G. Phillips Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs (Specify whether

In this community 2 month years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 1041 N Leggingwell St (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Jim Wallace

3. (b) If veteran, name war No

3. (c) Social Security No. 40

4. Sex M

5. Color or race Col

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

6. (b) Name of husband or wife Fannie Wallace

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased 4 (Month) 20 (Day) 1905 (Year)

8. AGE: Years 38 | Months 0 | Days 15 | If less than one day hr. min.

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

10. Usual occupation Truck Driver

11. Industry or business Farmer

MOTHER FATHER

12. Name Tom Wallace

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

14. Maiden name Harriat Owns

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

16. (a) Informant's own signature Clint Watkins

(b) Address 2614 Stoddard St

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-7-43 (Month) (Day) (Year)

(c) Place: burial or cremation Elysville Ark Harbrocemetery

18. (a) Signature of funeral director Gus Lowe

(b) Address 2930 Dickson St

19. (a) MAY 10 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1943 hour 7 minute P 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: I Hemorrhage 2 Perforated Duration
of Brain following being struck
over the head with a Pipe in
Due to the Hands of one
Fannie Wallace (Col) on the
Due to home at Elysherville Ark
March 1 - 1943 Exact time
Other conditions Unknown
(Include pregnancy within 3 months of death)

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) Homicide

(b) Date of occurrence March 1 - 1943

(c) Where did injury occur Elysherville Ark (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Unknown (Specify type of place)

While at work? (e) Means of injury

23. Signature Alfred Berry (M. D. or other)

Address Deputy Coroner Date signed 5/12/43

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should e CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor.

X19511

2 6
7 5 7

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~~ Mo

....., Registered Apprentice No....., working under my personal supervision.

Signed Claude Young

Licensed Embalmer No. 3371

P. O. Address St Louis

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1293 1

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 4240

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:
(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) Citizen of foreign country? (Yes or No)
If yes, name country

O.K. for

3. (a) PRINT FULL NAME Jim Wallace
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race B
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased April 20 (Month) (Day) 1905 (Year)

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Ark (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) (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) JUL 3 1943 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day year 1943 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY