

S. No. 2  
M-2-43  
5-17-39  
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40892

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 4 1944 318  
Registration District No. 318  
Primary Registration District No. 1003  
State File No. \_\_\_\_\_  
Registrar's No. 11726

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:  
3697 Hickory St.  
(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 MO. (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 918  
(d) Street No. 3697 Hickory St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME LUCILLE WALLACE  
3. (b) If veteran, name war None 3. (c) Social Security No. None  
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 Nov. 9th 1875  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 25th  
year 1943 hour 6 minute 30 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.

8. AGE: Years Months Days If less than one day  
68 1 16 hr. \_\_\_\_\_ min.

Immediate cause of death  
Chronic Myocarditis  
Chronic Endocarditis  
Myocarditis  
Due to \_\_\_\_\_  
Due to 151  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Shannon Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housework  
11. Industry or business at home  
12. Name James Wallace  
13. Birthplace Scottsburg  
(City, town, or county) (State or foreign country)  
14. Maiden name Lisa Elmer  
15. Birthplace Waterloo Illinois  
(City, town, or county) (State or foreign country)  
16. (a) Informant William Wallace  
(b) Address 4159 Herthing Block  
17. (a) Burial (b) Date thereof 12-28-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Burial Park  
18. (a) Signature of funeral director Wiegand Mortuary  
(b) Address 4228 So. Kings Highway  
19. (a) DEC 27 1943 (b) J. F. Prussack  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of Injury \_\_\_\_\_  
23. Signature Alfred Perry (M. D. or other)  
Address Springfield Date signed 12/27/43

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*City Carver*

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**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 *Edwin A. McPherson*.....

Licensed Embalmer No. *3029*.....

P. O. Address.....

**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, fact should be so stated above.**