DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

#17383

FILED MAR 9 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 1725

Registrar's No. 1724

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

1. PLACE OF DEATH:

(a) County ~

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Memorial
St. Louis City Hospital—Max. C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ~

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

(d) Street No. 5109 Market
(If rural, give location)

(e) Citizen of foreign country? O (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Wallace

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male | 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 June (Month) 11 (Day) 1874 (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	8	4	hr. min.

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

10. Usual occupation JANITOR

11. Industry or business

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

MOTHER
14. Maiden name Ann [illegible]
15. Birthplace N.Y. City (City, town, or county) NY (State or foreign country)

16. (a) Informant St. Vincent DePaul Soc
(b) Address 2333 Mullanphy

17. (a) Burial (Burial, cremation or removal) (b) Date thereof Feb 21-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Cullen Kelly
(b) Address 4386 Lindell

19. (a) FEB 21 1945 (Date received local registrar) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 15,
year 1945 hour 1:00 minute 05 P.M.

21. I hereby certify that I attended the deceased from February 4, 1945 to February 15, 1945; that I last saw him alive on February 15, 1945; and that death occurred on the date and hour stated above.

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

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 [signature] (M. D. or other)
Address 1535 Lafayette Date signed 2/24/45

(Licensed Embalmer's Statement on Reverse Side)

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 James G. Lammers

Licensed Embalmer No. 7142

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, fact should be so stated above.