S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

#53941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1003

State File No. 15294

Registration District No. 318 FILED MAY 2 1946

Primary Registration District No.

Registrar's No. 3719

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

(d) Length of stay: In hospital or institution 10 weeks (Specify whether
In this community 18 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St Louis 22 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1425 PARK Ave 19
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME WILLIAM WALLACE

3. (b) If veteran, name war no

3. (c) Social Security No. 497-10-8913

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife MARY

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased December (Month) 13 (Day) 1901 (Year)

8. AGE: Years 44 Months 4 Days 9 If less than one day hr. min.

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

10. Usual occupation Truck driver

11. Industry or business

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

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

16. (a) Informant Mary Wallace
(b) Address 1425 Park Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-46 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Missouri

18. (a) Signature of funeral director AW McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) (Date received local registrar) APR 23 1946 (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd year 1946 hour 3:57 minute A M.

21. I hereby certify that I attended the deceased from 2/9/46, 19, to 4/22/46, 19; that I last saw him alive on 4/22/46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death metastatic carcinoma of the brain

Due to Carcinoma of the lung

Due to Primary site lung

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

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 R. Thomas 1515 Lafayette (M.D. or other) 4/22/46

Address Date signed

(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.....L R Cooper.....

Licensed Embalmer No. 3633

P. O. Address 221 Lafayette

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.