

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19093**

FILED JUN 7 1946

Registration District No. **2197**

Primary Registration District No. **6079**

Registrar's No. **35**

1. PLACE OF DEATH:

(a) County **Ste. Genevieve**
(b) City or town **Rural, Ste. Genevieve Twp.**
(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)

3. (a) PRINT FULL NAME

Mamie M. Wallace

3. (b) If veteran, name war **Nil**

3. (c) Social Security No. **Unknown**

4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Howard I. Wallace** 6. (c) Age of husband or wife if alive years
7. Birth date of deceased **October 26 1894**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 6 22 hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **John J. Chesnick**
13. Birthplace **Unknown Poland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary E. Jasinski**
15. Birthplace **Unknown Poland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Thomas A. Wallace**
(b) Address **2939 Moniteau Dr.**
17. (a) **Burial** (b) Date thereof **5-22-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Doc C. Barker**
(b) Address **Ste. Genevieve Mo**
19. (a) **5-21-46** (b) **Seamus M. Paul**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Overland**
(If outside city or town limits, write "RURAL")
(d) Street No. **2408 Brown Rd.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **18**
year **1946** hour **2:05** minute **P.** M.

21. I hereby certify that I attended the deceased from
_____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Crushed chest due to auto-mobile wreck on Highway 32
Due to **Ste. Genevieve County, Mo.**
Accidental death.
Due to **(Verdict of Jury)**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

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) **Accident**
(b) Date of occurrence **May 18, 1946**
(c) Where did injury occur **Ste. Genevieve Co., Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Missouri State Highway 32

While at work? **No** (Specify type of place) (e) Means of injury **3**

23. Signature **Doc C. Barker** **Coroner**
Address **Ste. Genevieve Mo** (M.D. or other)
Date signed **5/14/46**

(Licensed Embalmer's Statement on Reverse Side)

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

NOV

1947

AUG 5 1948

OCT 28 1947

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

John Agonowski

Licensed Embalmer No. *3398*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 219

Primary Registration District No. 6079

Registrar's No. 31

1. PLACE OF DEATH:

(a) County St. Genevieve
(b) City or town Rural
(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)

3. (a) PRINT
FULL NAME

Mamie M. Wallace

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive.

7. Birth date of deceased Oct 26
(Month) (Day) (Year)

8. AGE: Years 51 Months Days If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

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) (Date received local registrar) (b) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 1946 year hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw him, alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to a collision with other motor vehicle
Due to

Other conditions (Include pregnancy within 3 months of death)

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) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

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

17971

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

AUG 6 1946

19093