

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003State File No. **29629**
Registrar's No. **8177**Registration District No. **318**

Primary Registration District No.

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: **Homer G Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether years, months or days) **50 YEARS**

3. (a) PRINT FULL NAME **Josie Wallace**

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **F** 3 Color or race **NEGRA** 5. Color or race **NEGRA**
6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **4-2-1859**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 4 21 hr. min.

9. Birthplace **ST CHARLES MD**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WORK**

11. Industry or business.....

12. Name **JOSEPH ALEXANDER**
13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **CARRIE CLAY**
15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Carrie Cook**
(b) Address **823 N 18th St**

17. (a) **BURIAL** (b) Date thereof **8-30-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **GREEN WOOD**

18. (a) Signature of funeral director **Bennie Lane**
(b) Address **3103 WASHINGTON AVE**

19. (a) **AUG 28 1947** (b) **J. J. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **509 S Garrison**
(If rural, give location)
(e) Citizen or foreign country? **18** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **23**
year **1947** hour **9** minute **12 P** M.

21. I hereby certify that I attended the deceased from **August 21** 19**47** to **August 23** 19**47**
that I last saw her alive on **August 23** 19**47**
and that death occurred on the date and hour stated above.

- Immediate cause of death **Gastric Malignancy** Duration **Undet.**

- Primary site not determined

- Due to.....

- Due to.....
Other conditions **None**
(Include pregnancy within 3 months of death)

- Major findings:
Of operations.....

- Of autopsy **No**

- PHYSICIAN

- Underline the cause of 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? **0**
(e) Means of injury.....
23. Signature **Oscar L Daniels** (M. D. or other)
Address **2601 N Whittier** Date signed **8/25/47**

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.....

Licensed Embalmer No.....

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.