

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6237**
Registrar's No. **1326**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS | | c. LENGTH OF STAY (In this place) 0 | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital | | d. STREET ADDRESS (If rural, give location) 4442 N MARKET | | | |

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|--|-----------------------------------|--|-------------------------------------|---|------------------------|
| 3. NAME OF DECEASED (Type or Print) WALLACE HALEY | | | 4. DATE OF DEATH Feb. 5 1949 | | |
| a. (First) | b. (Middle) | c. (Last) | Date (Month) | Date (Day) | Date (Year) |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE | 8. DATE OF BIRTH 1-1-04 | 9. AGE (In years last birthday) 45 | IF UNDER 1 YEAR Months |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) ST LOUIS | | 12. CITIZEN OF WHAT COUNTRY? 0 | |

| | | | | | |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME Edward NEALIOUS | | 13b. MOTHER'S MAIDEN NAME NANNIE JOHNSON | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME Edna Watson | |
| (If yes, give war or dates of service) | | | | ADDRESS 909 N. 19th | |

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|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lungs - Congestion, Pulmonary | | Undetermined | | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Organic Brain Disease | | | | |

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|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 11-22-, 19 48, to 2-5, 19 49, that I last saw the deceased alive on 2-5, 19 49, and that death occurred at 4:45 Pm., from the causes and on the date stated above.

| | | | | | |
|--|--|--|--|--|--|
| 23a. SIGNATURE (Degree or title) Oscar L Daniels M.D. | | 23b. ADDRESS 2601 N. White | | 23c. DATE SIGNED 2-10-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 2-11-49 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. | |
| 24d. LOCATION (City, town, or county) St. Louis | | 24e. (State) Mo | | 25. FUNERAL DIRECTOR'S SIGNATURE A. J. Walton | |
| DATE REC'D BY LOCAL REG. FEB 11 1949 | | REGISTRAR'S SIGNATURE J. B. Basater | | ADDRESS 2707 Stoddard | |

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4-2-2-1

P. O. Address 4049 St. Ferline

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.