

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43053**

FILED DEC 27 1949

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003** Registrar's No. **10844**

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

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>10844</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		?	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>6 1410 N. Euclid 6</b>			
3. NAME OF DECEASED (Type or Print) <b>Tony</b>		a. (First)		b. (Middle) <b>Wallace</b>		c. (Last)	
4. DATE OF DEATH		(Month) <b>Dec.</b>		(Day) <b>14</b>		(Year) <b>1949</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>2/28/1896</b>	
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b>		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Joseph Wallace</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Bowens</b>		14. NAME OF HUSBAND OR WIFE <b>Almira Wallace</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Almira Wallace, 1410 Euclid</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain - Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
		ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <b>Undetermined</b> DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					
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) <b>83</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>331X</b>			
22. I hereby certify that I attended the deceased from <b>12-11</b> , 19 <b>49</b> , to <b>12-14</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>12-14</b> , 19 <b>49</b> , and that death occurred at <b>9:40p m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Miss J. Hedrick M. D.</b>				23b. ADDRESS <b>2601 N Whittier St</b>		23c. DATE SIGNED <b>12-15-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12/19/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>DEC 17 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Laster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Chas. J. Gates, 4107 Finney Avenue</b>			

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**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 Thomas J. Tate

Licensed Embalmer No. 4259

P. O. Address 41077

**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.