

FILED DEC 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43310**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **04678**

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

1. PLACE OF DEATH a. COUNTY <b>Saint Louis.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>000</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Koch rural</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>26 Saint Louis</b>	
c. LENGTH OF STAY (in this place) <b>39 days</b>		d. STREET ADDRESS (If rural, give location) <b>1521 Deserchem</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>			

3. NAME OF DECEASED a. (First) <b>ROBERT</b> <i>Robert</i>		b. (Middle)		c. (Last) <b>WALLIS</b> <i>Wallis.</i>		4. DATE OF DEATH (Month) (Day) (Year) <b>12-12-49</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <b>widower</b>		8. DATE OF BIRTH <b>1-6-77</b>	
9. AGE (in years last birthday) <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>will.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Saint Louis Mo</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>u.s.a</b>		13a. FATHER'S NAME <b>Roger Wallis</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Burton</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <b>Mary Henryson deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO. <b>493-24 9454</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Records of Robert Koch Hospital</b>		ADDRESS <b>Koch, Mo</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one year?</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>002X</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)		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 **11-4-**, 19**49**, to **12-12-**, 19**49**, that I last saw the deceased alive on **12-12-**, 19**49**, and that death occurred at **6:34 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Harold G. Russell, MD</b>		23b. ADDRESS <b>Robert Koch Hosp. Koch, Mo</b>		23c. DATE SIGNED <b>12-13-49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>12-15-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>12-14-49</b>		REGISTRAR'S SIGNATURE <b>Hubert K. Laska, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros.</b>		ADDRESS <b>3320 N. Kingshighway</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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Fred Frick*

Licensed Embalmer No. 3186

P. O. Address St. Louis MO.

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.