No. 300
10.48

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

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35426
Registrar's No. 9136

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

1. PLACE OF DEATH
a. COUNTY —
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BARNES HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Collinsville 62234
d. STREET ADDRESS (If rural, give location): 614 No Vandalia

3. NAME OF DECEASED (Type or Print): a. (First) Emil b. (Middle) Joseph c. (Last) Wall
4. DATE OF DEATH (Month) (Day) (Year): Oct. 22, 1950
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-9-~~18-66~~ 1877
9. AGE (In years last birthday): 73 8-4 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal
11. BIRTHPLACE (State or foreign country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Joseph Wall
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Celia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Celia Wall ADDRESS: Collinsville Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma metastatic to brain — 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic carcinoma, Rt. Lung — 10 months
DUE TO (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.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-25-50
19b. MAJOR FINDINGS OF OPERATION: Metastatic carcinoma of cerebrum
20. AUTOPSY? YES [X] NO [ ]

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 [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 162X

22. *I hereby certify that I attended the deceased from* Oct. 22, 19 50, *to* Oct. 26, 19 50, *that I last saw the deceased alive on* Oct. 26, 19 50, *and that death occurred at* 2:40P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Eugene T. Standley (Degree or title) M.D.
23b. ADDRESS: BARNES HOSPITAL
23c. DATE SIGNED: 10/26/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-27-50
24c. NAME OF CEMETERY ~~OR CREMATORY~~: St Johns
24d. LOCATION (City, town, or county) (State): Collinsville Ill

DATE REC'D BY LOCAL REG.: OCT 27 1950
REGISTRAR'S SIGNATURE: J. B. Sasseen
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Signed Ronald O Yahnke

Signed.....
Student Embalmer

Licensed Embalmer No. 3917

P. O. Address [illegible]

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.

State of Mo
County of St Louis } ss.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

AFFIDAVIT FOR CORRECTION OF A RECORD

State File No. 35426-50
Local Registrar's No. 9136

On this 24th day of November, 1950, before me appears Howard F Rowland, who, upon his oath, states that the original record of ~~birth~~ death for Emile Wace died ~~born~~ 10-26, 1950, in the State of Missouri, and which was filed at St Louis on 10-27, 1950, should be corrected as follows:

Item No. 8 should read 9-9-1877
Instead of 9-9-1866

Item No. 9 should read 73
Instead of 84

Item No. ..... should read .....
Instead of .....

Item No. ..... should read .....
Instead of .....

Item No. ..... should read .....
Instead of .....

Item No. ..... should read .....
Instead of .....

Item No. ..... should read .....
Instead of .....

Item No. ..... should read .....
Instead of .....

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant Howard F Rowland
Relationship.

4104 Manchester,
Present Address.

Subscribed and sworn to before me this 26th day of November, 1950.

My Commission expires May 13-1952 Norman S. Roth Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

n V. S. 135
M—4-43
I X36667