

FILED OCT 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35429
Registrar's No. 8778

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). STATE 111013 b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN E. St. Louis 8177	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's IMF		d. STREET ADDRESS (If rural, give location) 1531 Market Ave.	
3. NAME OF DECEASED a. (First) IRA		b. (Middle) BELLE	
c. (Last) WALLACE		4. DATE OF DEATH (Month) (Day) (Year) 10 - 14 - 50.	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/6/78
9. AGE (In years last birthday) 72		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Commerce Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Wesley Sykes	
14. MOTHER'S MAIDEN NAME SUSAN GAITHER		15. NAME OF HUSBAND OR WIFE WALTER WALLACE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Obstetric labor</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Nephritis</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
20. INTERVAL BETWEEN ONSET AND DEATH		21. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. DATE OF OPERATION		23. MAJOR FINDINGS OF OPERATION	
24. ACCIDENT SUICIDE HOMICIDE (Specify)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		27. HOW DID INJURY OCCUR H90X	
28. TIME OF INJURY (Month) (Day) (Year) (Hour)		29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
30. I hereby certify that I attended the deceased from 10/50 to 10/14, 1950, that I last saw the deceased alive on 10/14, 1950, and that death occurred at 2:40 a.m., from the causes and on the date stated above.			
31. SIGNATURE <u>E. J. Warden</u> (Degree or title)		32. ADDRESS <u>925 N. 2nd St</u>	
33. DATE SIGNED 10/14/50		34. BIRTHAL CREMATION REMOVAL	
35. DATE 10/18/50		36. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
37. LOCATION (City, town, or county) St. Louis		38. STATE	
39. DATE REC'D BY LOCAL REG. OCT 17 1950		40. REGISTRAR'S SIGNATURE J. B. Fasater	
41. FUNERAL DIRECTOR'S SIGNATURE RMC Green		42. ADDRESS 3517 Laeche	

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

1960 m

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 Melvin E. Green

Licensed Embalmer No. 4428

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.