

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6931

State File No.

318

1003

Registrar's No. 1897

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give town or township)
ST. LOUIS, MISSOURI

c. CITY OR TOWN
St. Louis

d. In Residence within limits of a city or incorporated town?
Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION
ST. LOUIS CITY HOSPITAL

e. STREET ADDRESS (If rural, give location)
Unknown

3. NAME OF DECEASED
a. (First) **ROBERT** b. (Middle) **WALLACE** c. (Last) **MICHAEL**

4. DATE OF DEATH
(Month) (Day) (Year)
FEB. 19, 1956.

5. SEX
Male

6. COLOR OR RACE
White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Never Married

8. DATE OF BIRTH
Dec. 6, 1918

9. AGE (In years last birthday) Months Days Hours Min.
37

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
Diehlstadt, Mo.

12. CITIZEN OF WHAT COUNTRY?
U.S.

13a. FATHER'S NAME
Will Michael

13b. MOTHER'S MAIDEN NAME
Clara Watkins

14. NAME OF HUSBAND OR WIFE
None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW II

16. SOCIAL SECURITY NO.
493-32-9701

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Clara Michael, Charleston, Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Alcoholic neuropathy**
ANTECEDENT CAUSES **Chronic alcoholism**
Morbidity 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.
Multiple sclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
322-1

20. AUTOPSY?
YES 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?

22. I hereby certify that I attended the deceased from **12-31**, 19**55** to **2-19**, 19**56**, that I last saw the deceased alive on **2-19**, 19**56**, and that death occurred at **4:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Albert H. Hoppe - MD

23b. ADDRESS
1515 LAFAYETTE AVE.

23c. DATE SIGNED
2-21-56.

24a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

24b. DATE
2-20-56

24c. NAME OF CEMETERY OR CREMATORY
Odd Fellows

24d. LOCATION (City, town, or county) (State)
Charleston, Mo.

DATE REC'D BY LOCAL REG.
FEB 23 1956

REGISTRAR'S SIGNATURE
Albert H. Hoppe

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Albert H. Hoppe, 4700 Washington Blvd.

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

MAR. 5 1956

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.....
Signature of Student Embalmer

Signed *Elmer R. Sadwell*.....

Licensed Embalmer No. *40*

P. O. Address *H. Lou*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.