

Health, Welfare, Public Service  
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 1-56  
 ALL  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 15 1957

THE DIVISION OF REALTY OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

44030

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11800**

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>		Length of stay in lb <b>26</b>		STREET ADDRESS <b>5916 Washington Blvd.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>First WILLIAM Middle LEE Last WALLIN</b>				4. DATE OF DEATH <b>Dec. 24, 1956</b> Month Day Year				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1891</b>		
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>machinist</b>		11. BIRTHPLACE (City and state or country) <b>Winona, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN C. WALLIN</b>				14. MOTHER'S MAIDEN NAME <b>Ophelia Russell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>497-01-1531</b>		17. INFORMANT (wife) Address <b>Mrs. Alice Wallin, 5916 Washington Bl.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myo. Carditis Chronic (Myocarditis-chronic)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>422.2</b>							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>Oct-10</b> , to <b>Dec-24</b> and last saw her/him alive on <b>Dec-27</b> . Death occurred at <b>6:30 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>T. H. Hale</b> (Degree or title) <b>M. D.</b>				22b. ADDRESS <b>4903 Delmar</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE <b>Dec. 27, 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons, 6175 Delmar Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 24 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>		

(Licensed Embalmer's Statement on Reverse Side)

Dr. Hale

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 *Jos. E. McCulloch*

Licensed Embalmer No. *27*

P. O. Address *61402*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.