

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-042671
STATE FILE NUMBER

FILED VS NOV 16 1959

2 9454

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

V. S. 300
Rev. 1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Ferguson 4000	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS 434 Jean (If outside, give location) 343 Jane Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Wallace		4. DATE OF DEATH Month Day Year 10 14 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/59
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Wallace		13b. MOTHER'S MAIDEN NAME Julia Veresche Florence Kife	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT George E. Haller
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure Hydrocephalus DUE TO (b) DUE TO (c) 752x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Face Pros - dlytacia labor - Versoon Ectoderm			INTERVAL BETWEEN ONSET AND DEATH 50 "
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from Death occurred at 9:21 8:31 pm 10/14/59 to 10/14/59 and last saw her alive on 10/14/59		22. SIGNATURE (Degree or title) Roy v. Baedeker M.D.	
22a. ADDRESS 100 N. Euclid		22c. DATE SIGNED 10/14/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-16-59	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri (State)	
24. FUNERAL DIRECTOR ADDRESS Mullen 118 N. Florissant Rd.		25. DATE RECD. BY LOCAL REG. OCT 15 59	
26. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

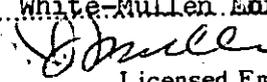
securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 No Embalming, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed White-Mullen Mortuary Inc.

Licensed Embalmer No.
P. O. Address

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.