

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

SL 4003

8843-61-035081
STATE FILE NUMBER

Registration District No. 318

Primary Registration District No.

Registrar's No.

AMENDED

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 45 DAYS	c. CITY OR TOWN VENICE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 910 MAIN STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RAY Middle E. Last WALLACE			4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-8-16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) YES LABORER		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (last birthday) 45 IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) SALEM, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOHN WALLACE		13b. MOTHER'S MAIDEN NAME MARTHA PACE	14. NAME OF HUSBAND OR WIFE BETTY WALLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT BETTY WALLACE Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INSUFFICIENCY DUE TO (b) TO MEDEASTINUM SHIFT DUE TO (c) HEMORRHAGE IN RIGHT PLURAL CAVITY AND MEDEASTINAL PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 521X PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 8-8-61 to 8-21-61 and last saw him ^{her} alive on 9-21-61 Death occurred at 8:20 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) SANFORD WOLFSON		22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 9-23-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 27, 1961	23c. NAME OF CEMETERY OR CREMATORY St. John's	23d. LOCATION (City, town, or county) (State) Granite City, Illinois
24. FUNERAL DIRECTOR ADDRESS Francis J. Jolley Madison, Ill.		25. DATE RECD. BY LOCAL REG. SEP 24 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED

ITEM NO. SHOULD READ INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT
G. W. Wolfson, M.D., Registrar

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

Francis J. Fahy

Licensed Embalmer No. 2792

P. O. Address Madison Ill.

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.