ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-043007
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10953

FILED DEC 1 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis — Length of stay in 1b 20 yrs. 1 mo. 2 days

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis State Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1305 N. Broadway — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First GERTRUDE Middle Last WALLACE

4. DATE OF DEATH Month Nov. Day 22, Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒

8. DATE OF BIRTH 11/7/1907

9. AGE (last birthday) 54 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Walnut Ridge, Arkansas

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Unknown Wallace

13b. MOTHER'S MAIDEN NAME Frances (Bello[illegible])

14. NAME OF HUSBAND OR WIFE Joseph Jennings

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

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Bernice Jennings, 736 Waveland Avenue., Chicago, 13, Illinois.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cardiac Failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Acute pulmonary edema

DUE TO (c) Cirrhosis of Liver 581.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Cirrhosis with ascites

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 10-20-41, to 11-22-61 and last saw her/him alive on 11-22-61

Death occurred at 4:50 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. Hopp Caller M.D.

22b. ADDRESS 5400 Arsenal St.

22c. DATE SIGNED 11-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11/24/61

23c. NAME OF CEMETERY OR CREMATORY Lane Cemetery

23d. LOCATION (City, town, or county) (State) Walnut Ridge, Arkansas.

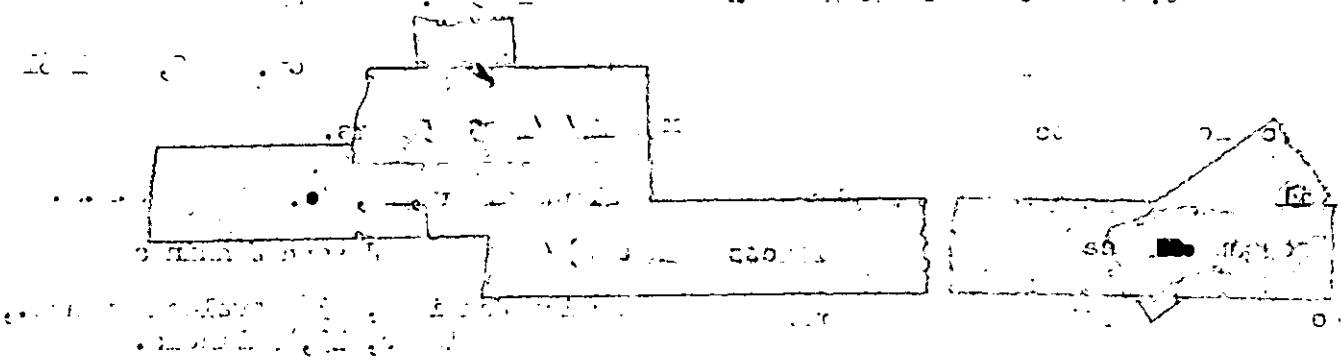
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. NOV 24 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

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 _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J. W. Pinkley

Licensed Embalmer No. 3653

P. O. Address [illegible]

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.