MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH.

PLACE OF DEATH

County Jasper

Township ____ or Village ____ or City Joplin (No. 106 Joplin St.; ____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5659

Registration District No. 411 File No. ____

Primary Registration District No. 2002 Registered No. 56

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph Wallace

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

DATE OF BIRTH Don't Know. (Month) (Day) (Year)

AGE 30 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Rd Carrier
(b) General nature of industry, business, or establishment in which employed (or employer) 3-07

BIRTHPLACE (City or town, State or foreign country) Neosho Mo.

PARENTS
- NAME OF FATHER. Joe Wallace.
- BIRTHPLACE OF FATHER (City or town, State or foreign country) Alabama
- MAIDEN NAME OF MOTHER. Don't Know.
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Wallace

(ADDRESS) Big Cabin O.K.

Filed Feb 10, 1913. A M Gregg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb (Month) 7 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1913, to Feb 7, 1913, that I last saw h[illegible] alive on Feb 1, 1913, and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

33A

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W H Mallory M. D.

Feb 10, 1913. (Address) Joplin

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Fairview — DATE OF BURIAL Feb 10, 1913

UNDERTAKER Hulbert — ADDRESS Joplin Mo

MISSOURI STATE BOARD OF HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____ (NO._____, _____ St.; _____ Ward)

[If death occurre
hospital or insti
give its NAME
of street and numl

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____. _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, _____
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

_____, 191____, to _____, 19__

that I last saw h_____ alive on _____, 19__

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) ____ yrs. ____ mos. ____

Contributory _____
(Secondary)

_____ (Duration) ____ yrs. ____ mos. ____

(Signed)_____ M

_____, 191____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 19
UNDERTAKER	**ADDRESS**

Revised Ur