WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County: Bollinger Co

Township: Lorance

or Village:

or City: (No. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 1026

Primary Registration District No. ~~5105~~ 5102A

File No. 122015

Registered No. 17

FULL NAME Alexander Gray Wallis

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Male
COLOR OR RACE	W
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	married
DATE OF BIRTH (Month) (Day) (Year)	Nov 7th, 1859
AGE	53 yrs. 8 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work	farmer
(b) General nature of industry, business, or establishment in which employed (or employer)	—
BIRTHPLACE (City or town, State or foreign country)	North Carolina
PARENTS: NAME OF FATHER	Stimpson Wallis
BIRTHPLACE OF FATHER (City or town, State or foreign country)	not known
MAIDEN NAME OF MOTHER	Falonia Steid
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Wallis

(ADDRESS) Paducah, Ky.

Filed July 14, 1913 W W Davault MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 9, 1913, to July 12, 1913, that I last saw him alive on July 12, 1913, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Strangulated hernea Inguinal 1 2 2 A (Duration) 7 yrs. ___ mos. ___ ds.

Contributory (Secondary) Hereditary (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W Webster Davault M. D.

___ 191__ (Address) Glen allen Mo

*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: McGee Chapple — DATE OF BURIAL: July 13, 1913

UNDERTAKER: J. A. Berry — ADDRESS: Glen allen Mo

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed)..... M. D.

....., 191..... (Address).....

*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	DATE OF BURIAL ....., 191...
UNDERTAKER	ADDRESS