

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

20745

1. PLACE OF DEATH

County Jasper
Township Jasper
City Joplin (No. 220367th)

Registration District No. 411
Primary Registration District No. 2002

File No. 300
Registered No. 300
St. Mo. Ward 1st

2. FULL NAME

(a) Residence, No. Ray Wallace St. Mo. Ward 1st
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ray Wallace

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 26 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
1 4 18 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) Joplin Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Oscar Wallace

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Leaher Dillon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Oscar Wallace
(Address) Joplin Mo.

15. FILED 7/14 1924 Wm. S. Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 16 1924

17. I HEREBY CERTIFY, That I attended deceased from July 16 1924 until I last saw him alive on July 16 1924 and that death occurred, on the date stated above, at 8-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro-ileocolitis
119.8 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 113 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Mo.

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF —

WAS THERE AN AUTOPSY? —

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ed. P. James, M. D.

7-17 1924 (Address) Joplin Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Park

DATE OF BURIAL 7-17 1924

20. UNDERTAKER Humboldt Co.

ADDRESS Joplin Mo.

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.

LOCAL REGISTRAR'S REPORT--DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... Sl. Ward)

2. FULL NAME

(a) Residence, No..... Sl..... Word.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. d.s. How long in U.S., if of foreign birth? yrs. mos. d.s.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., 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:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. d.s.

18. WHERE WAS DISEASE CONTRACTED (duration)..... yrs. mos. d.s.

IF NOT AT PLACE OF DEATH..... DATE OF.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., 19 (Address)....., M. D

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS