

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

Do not use this space.

17279

**1. PLACE OF DEATH**

County..... Stoddard  
Township..... Liberty  
City..... (No. ....) .....

Registration District No. .... 838  
Primary Registration District No. .... 6098B

File No. ....  
Registered No. .... 93  
St. .... Ward)

**2. FULL NAME**

Lossie Wallace

(a) Residence. No. .... St., .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25 - 1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>about</u>	<u>23</u>	<u>4</u>	<u>15</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Part maker  
(b) General nature of industry, business, or establishment in which employed (or employer) worked in a part factory  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; (STATE OR COUNTRY) Jackson Tenn.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT R. B. Muncan  
(Address) 336 W. Broadway, Mayfield Ky.

15. FILED 5/13, 1927 F. Haber  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-12 1927

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to May 12, 1927 that I last saw her alive on May 12, 1927, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
pulmonary tuberculosis

23 A 31 (duration) - yrs. 7 mos. - ds.

CONTRIBUTORY (SECONDARY) None  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. ✓

0 DID AN OPERATION PRECEDE DEATH. no DATE OF ✓  
WAS THERE AN AUTOPSY. no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) Frank Haber, M. D.  
, 19 (Address) Nexes 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bear Creek Tenn. DATE OF BURIAL 5-15-1927

20. UNDERTAKER E O Biggs ADDRESS Nexes 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.

