

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

Do not use this space.

10300

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.

1. PLACE OF DEATH
 APR 24 1929 Greene Registration District No. 318
 Township..... Primary Registration District No. 2007
 City Springfield (No.....) St. Ward)

File No. 219
 Registered No. 52160410

2. FULL NAME Leroy Edward Wallace
 (a) Residence, No. 1112 E. McDaniel 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 14, 1909
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
19 5 29

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 19 29
17. NOV 23 I HEREBY CERTIFY That I attended deceased from 1928 to March 13 19 29
 that I last saw him alive on March 10 19 29, and that death occurred on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

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

CONTRIBUTORY (SECONDARY) Typhoid and Exhaustion
 (duration) yrs. mos. ds. 4

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield, Mo. Missouri

18. WHERE WAS DISEASE CONTRACTED Don't know
 IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER William Edward Wallace

DID AN OPERATION PRECEDE DEATH? No DATE OF.....
 WAS THERE AN AUTOPSY? No

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

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic
Shellin (Signed) M. D.

12. MAIDEN NAME OF MOTHER Ada Roberson

(Address) 318 College St

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

*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.

14. INFORMANT Mrs. Ada Wallace Bedell
 (Address) 1112 - E - McDaniel

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hazelwood Cemetery **DATE OF BURIAL** Mar - 17 1929

15. FILED 2-16 19 29 Lon Sharp REGISTRAR
Lon Sharp

20. UNDERTAKER Herbert V Smith
 ADDRESS 603 - N. Jefferson A.

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29
2

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