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

Do not use this space.
10812

File No.
Registered No.

1. PLACE OF DEATH
County Jackson Registration District No.
Township Kaw Primary Registration District No.
City Kansas City (No. General Hospital St. Ward)

2. FULL NAME Wallace Lee
(a) Residence. No. 1501 admiral St., 1 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 21 1868

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	11	24	

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

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

PARENTS
10. NAME OF FATHER Geo. Wallace
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Penn.
12. MAIDEN NAME OF MOTHER Jennie Linsey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Penn.

14. INFORMANT Record Clerk
(Address) K.C. Genl Hosp

15. Filed 3/16, 19 29 M. M. Browne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-14, 1928, to 3-15, 1929 that I last saw him alive on 3-15, 1929 and that death occurred, on the date stated above, at 9:25 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lymphoblastoma
Coma (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS

(Signed) P E Wilcoxen, M. D.
3/15, 1929 (Address) K.C. Genral Hosp.

*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	DATE OF BURIAL
Maplehill	Mar 16 1929
20. UNDERTAKER Ketterlin	ADDRESS City

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH

County .... Registration District No. 399 File No. ....

Township K. C. Primary Registration District No. 1002 Registered No. 1321

City K. City (No. .... St. .... Ward)

2. FULL NAME Wallace Lee

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

PERSONAL AND STATISTICAL PARTICULARS

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

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)

PARENTS

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 3/16, 1929 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/15 1929

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 ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
[illegible] (malignant) generalized metastases primary focus not determined (duration) ....yrs. ....mos. ....ds.

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

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

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

WAS THERE AN AUTOPSY? ....

WHAT TEST CONFIRMED DIAGNOSIS? ....

(Signed) ...., M. D

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

S-10812