

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

Do not use this space.

27560

**1. PLACE OF DEATH**

County Hickory  
Township Wheatland  
City Wheatland (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 359  
Primary Registration District No. 3504

File No. \_\_\_\_\_  
Registered No. 8

**2. FULL NAME**

Emilio B 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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
34 11 28

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Madison Co Mo  
(STATE OR COUNTRY) Canada

10. NAME OF FATHER Jos. E. Wallace

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

12. MAIDEN NAME OF MOTHER Angeline E. Wyke

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

14. INFORMANT James E. Wallace  
(Address) Wheatland Mo

15. FILED 9/24 1929 Mrs. S. G. Gentry  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1929

17. I HEREBY CERTIFY That I attended deceased from Nov 21st 1928 to Aug 19th 1929  
that I last saw him alive on Aug 19th 1929 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Tuberculosis of the lymphatic glands  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 36  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF Mar 22 1929

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam  
(Signed) J. H. Murray M. D.  
(Address) Quincy 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 Parrett & Gove DATE OF BURIAL Aug 20 1929

20. UNDERTAKER J. H. Luckey ADDRESS Wheatland

PARENTS



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Dickson  
Township Waubesa  
City (No. ....) St. .... Ward)

Registration District No. 339  
Primary Registration District No. 3304

File No. ....  
Registered No. 8

**2. FULL NAME**

Deville B. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 21-1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
34 11 28

**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 9/20, 1929 Mrs. S. C. Gentry REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

..... (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

SUPPLEMENTARY

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

S-27560