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.

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

Do not use this space.

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1. PLACE OF DEATH
County Clay
Township Fishing River
City Excelsior Springs (No. .... St. .... Ward)

Registration District No. 198
Primary Registration District No. 3011

File No. ....
Registered No. 6

2. FULL NAME Jessie William Wallace

(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)
Male	white	child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 17 1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
	4	3	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(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) Kansas

PARENTS
10. NAME OF FATHER Jessie Wallace
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Lena Scharff
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Jesse Wallace
(Address) Excelsior Springs

15. FILED 1-13, 1930 Y. D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 12, 1930 that I last saw him alive on Jan 12, 1930, and that death occurred, on the date stated above, at 10 15 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107A
(duration) ... yrs. ... mos. ... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? no
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical symptoms
(Signed) S. P. McCracken, M. D.
1-13, 1930 (Address) Excelsior Spgs 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 Crown Hill
DATE OF BURIAL Jan 14 1930

20. UNDERTAKER Herbert Hope
ADDRESS Excelsior Springs Mo