

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

Do not use this space.

19222

PLACE OF DEATH

County Harrison
Township Clay
City _____ (No. _____) St. _____ Ward _____

Registration District No. 335
Primary Registration District No. 5470

File No. 17
Registered No. _____

2. FULL NAME Mabel May 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 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug - 12 - 1922

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, ____ hrs. or ____ min.**
7 9 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) Bethesda Md

10. NAME OF FATHER David Wallace

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

12. MAIDEN NAME OF MOTHER Grace Damm

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

14. INFORMANT Mrs Grace Wallace
(Address) Bethesda Md

15. FILED 7/9/30 H. J. Casper
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930

17. I HEREBY CERTIFY That I attended deceased from June 6, 1930 to June 10, 1930
that I last saw h. or alive on June 10, 1930, and that death occurred, on the date stated above, at 6:45 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningococcus meningitis

CONTRIBUTORY (SECONDARY) nil (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED no
IF NOT AT PLACE OF DEATH. no

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Leucocytes blood fluid
(Signed) H. J. Casper M. D.

June 10, 1930 (Address) Eagleville 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 Clear Hill Cemetery

DATE OF BURIAL 6/11/30

20. UNDERTAKER Frank H. Casper

ADDRESS Eagleville 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.

