

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 required.

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

Do not use this space.

27701

1. PLACE OF DEATH

County Cape Girardeau
Township Shawnee
City Keokuk Landing Mo. (No.) St. Ward)

Registration District No. 129
Primary Registration District No. 5180

File No.
Registered No. 19

2. FULL NAME

Bertha Wallace
(a) Residence, No. Keokuk Landing ... Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 30th 1925

7. AGE YEARS 7 MONTHS 2 DAYS 18 If LESS than 1 day, ... hrs. or ... min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) None 11. Total time (years) spent in this occupation None

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wheatley, Ark.

13. NAME (Father) Milton Wallace

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) (Father) Wheatley, Ark.

15. MAIDEN NAME (Mother) Rosie Wallace Benfield

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) (Mother) Wheatley, Ark.

17. INFORMANT (ADDRESS) Milton Wallace Keokuk Landing

18. BURIAL, CREMATION, OR REMOVAL PLACE Keokuk Landing DATE Aug. 18 1931

19. UNDERTAKER (ADDRESS) None Home made Coffin

20. FILED Aug 28, 1931 F. J. Schoen Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 17, 1931

22. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Dec 6, 1930

I last saw him alive on Dec 1, 1930. Death is said to have occurred on the date stated above, at 11:30 a.m.

The principal cause of death and related causes of importance were as follows:
Spine (by father) followed by paralysis

Other contributory causes of importance:
Bed pans - 184

Name of operation Bed pans - 184 Date of 184

What test confirmed diagnosis? 184 Was there an autopsy? 184

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? 184 Date of injury 184

Where did injury occur? 184 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury 184
Nature of injury 184

24. Was disease or injury in any way related to occupation of deceased? 184

(Signed) 184, M. D.

(Address) 184

SEP 22 1931

DR. CARL A. W. ZIMMERMANN
521A BROADWAY
CAPE GIRARDEAU, MISSOURI

~~27102~~

Aug 26/31

Mr. Milton Wallace

Neely's Laundry

Dear Sir:

Upon my return from a trip I found in the mail the uncompleted death certificate of your daughter Beitha -

Since I had not seen this girl after Dec. 1 - 1930. & know nothing about the subsequent history of the case I can not complete the paper.

I can say that Beitha was under my care from Sept 7 to Dec 1/30 in a state of paralysis of the lower 1/2 of the body as a result of injury to the spinal cord resulting from a gun shot wound.

I can further state it was rather miraculous that she clung to life as long as she did that such an injury could be the cause of her death any time.

You should get her last doctor to sign the certificate. - If you did not have another doctor, inclose this letter with the certificate.

Yours respectfully,

D. Carl All Zimmerman

P. S. More than likely you will be called upon to explain the accidental nature of the wound.

5-27401

**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 Cape Girardeau Registration District No. 129 File No.
Township Shannon Primary Registration District No. 3180 Registered No. 19
City (No.) St. Ward)

2. FULL NAME

Bertha 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 1925

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 (duration) yrs. mos. ds.
(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)

Please have physician sign. If there was no attending physician have coroner or health officer sign.
There was no physician.

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

14. INFORMANT (Address)

15. FILE # 9-30-31 F. J. Schorn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 1931

17. I HEREBY CERTIFY That I attended deceased from 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

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) E. R. Schorn Health Officer, M. D.
Jackson Mo
9-30-31 (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

20. UNDERTAKER ADDRESS

N. B.—Every item of informant should be carefully scrutinized. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

icated by check marks, lacking from the death certificate:

Name: Bertha Wallace
Who died at: Cape Girardeau, Mo. on Aug. 17, 1931,
Residence: No. _____

Length of residence in _____ (county, city or town)
town _____ Days _____

Sex: _____ divorced: _____

Date of birth _____ Days _____

Occupation: _____

Birthplace (county, city or town) _____

Birthplace of _____

Birthplace of _____

CAUSE OF DEATH: Gun shot wound of spine (by father) followed by paralysis.

Contributory: (Bed sores) Accident Discharge

Where was disease contracted? of Gun by Father in taking Gun down from the Gun Rack.

Did operation precede death? no Date of _____

Was there an autopsy? no What test confirmed diagnosis? _____

Was death due to homicide or accident?
This is all the information I can give you on the death of this child
F. J. Schorn