

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.

FEB 20 1935

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County CassRegistration District No. 135Township CassettownPrimary Registration District No. 5188City Cassettown

(No. \_\_\_\_\_)

File No. 466Registered No. 8

St. \_\_\_\_\_

Ward \_\_\_\_\_

2. FULL NAME Louie M Wallace

(a) Residence, No. \_\_\_\_\_

(Usual place of abode)

St. \_\_\_\_\_

Ward \_\_\_\_\_

(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

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

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

XXX

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

1-10-1867

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.

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OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Shelbysville, Penn

13. NAME

Jack Wallace

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kentucky

15. MAIDEN NAME

Ram King

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kentucky

17. INFORMANT (ADDRESS)

W. M. Wallace, Cassettown, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Cassettown, MoDATE 1-12-1935

19. UNDERTAKER (ADDRESS)

Williston Funeral Home, Cassettown, Mo20. FILED 1-11-19351935With Haskins

Registrar.

## MEDICAL CERTIFICATE OF DEATH

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

1-10-1935

22. I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1935, to 1-9-1935I last saw him alive on Jan 9, 1935 Death is saidto have occurred on the date stated above, at 6 a. m.

The principal cause of death and related causes of importance were as follows:

Date of onset

myocarditis

Other contributory causes of importance:

Focal infection of teeth

Name of operation

Date of \_\_\_\_\_

What test confirmed diagnosis?

Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur?

(Specify city or town, county, and State)

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

Manner of injury

Nature of injury

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

If so, specify

(Signed) B. C. Cole (B. C. Cole), M. D.(Address) Norborne Mo

