

MAY 24 1935

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

Do not use this space.

12959

1. PLACE OF DEATH

County

Township

City

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

Length of residence in city or town where death occurred

Registration District No.

Primary Registration District No.

St.

Ward.

File No.

Registered No.

St.

Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

OCCUPATION

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

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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. UNDERTAKER (ADDRESS)

20. FILED

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

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

Date of onset

Other contributory causes of importance:

Name of operation

What test confirms diagnosis?

Date of 1935

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

Accident, suicide, or homicide? Date of injury

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)

(Address)

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.

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

St. Joseph Hospital
 1. PLACE OF DEATH *Jackson* Registration District No. *1000*
R. 2nd Primary Registration District No. *1302*
Kansas City (No. _____) St. _____ Ward _____
 2. FULL NAME *Margie Wallace*
 (a) Residence, No. _____ St. _____ Ward. *Clinton, Mo.*
 (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 *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) *1912-4-29*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
~~22~~ *22* *11* *18*
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *unemployed*
 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) *Clinton Mo.*
 13. NAME *Irwin H. Wallace*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 15. MAIDEN NAME *Rose Todd*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Utah Mo.*
 17. INFORMANT (ADDRESS) *Charlie Perrine Clinton, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL *Cons. Clinton, Mo.*
 PLACE *Englewood* DATE *April 19, 1935*
 19. UNDERTAKER (ADDRESS) *Wilkinson Clinton, Mo.*
 20. FILED *4-17, 1935 M. M. Crowe, M.D. Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 17, 1935*
 22. I HEREBY CERTIFY, That I attended deceased from *Deputy Coronary*, 19____
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at *1155 P.M.*
 The principal cause of death and related causes of importance were as follows:
Bilateral Pneumonia and Concussion of Brain
 Date of onset *163*
 Other contributory causes of importance:
trauma from fall against radiator
and Anaxial (2600)
 Name of operation *Op. for ungula* Date of 1935 _____
 What test confirms diagnosis? _____ Was there an autopsy? *yes*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury *4/13, 1935*
 Where did injury occur? *Coronado Hotel*
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury *Fall against radiator*
 Nature of injury *Concussion of brain*
 24. Was disease or injury in any way related to occupation of deceased? *No.*
 If so, specify _____
 (Signed) *St. Joseph Hospital*, M. D.
 (Address) *St. Joseph Hospital*

