OCT 15 1936

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

Do not use this space.

34350

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Blue — Primary Registration District No. 1002
City Kansas City (No. Linda V.A. Hospital St. Ward) — File No. — Registered No. 2060

2. FULL NAME John Wallace
(a) Residence, No. 1227 Jefferson 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	Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 14, 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	71	6	17	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. City Water Dept.
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) Illinois K. C. Mo

FATHER
13. NAME Milligan Wallace
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER
15. MAIDEN NAME Mary Jane Conlan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) K. C. J. B Hosp.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Calvary DATE Sept 4 1936

19. UNDERTAKER Quirk & Gobel Co.
(ADDRESS) 20 W Linwood

20. FILED 9-2 1936 M. M. Crowe asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 1 1936

22. I HEREBY CERTIFY, That I attended deceased from April 25, 1936, to Sept 1, 1936
I last saw him alive on Sept 1, 1936 Death is said to have occurred on the date stated above, at 4:00 pm.
The principal cause of death and related causes of importance were as follows:

	Date of onset
(a) Pulmonary Tuberculosis	
(b)	
(c)	
(d)	

Other contributory causes of importance:

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) [signature] M.D.
(Address) Kansas City 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.