

REC'D JUN 21 1939

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

18935
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 416
(b) Township Sarcoxie Primary Registration District No. 7248
(c) City Sarcoxie (d) Street No. _____ St.
(e) Length of residence in city or town where death occurred 11 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF _____
(OR) WIFE OF Margaret E Wallace

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 1 18

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

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

10. Data deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) Des Moines, Iowa
(STATE OR COUNTRY)

13. NAME James Wallace

14. BIRTHPLACE (CITY OR TOWN) Des Moines
(STATE OR COUNTRY) Iowa

15. MAIDEN NAME Dont Know

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

17. INFORMANT Mrs. Mildred Wallace
(ADDRESS) Sarcoxie, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Sarcoxie Cem, DATE 5/17 39

19. FUNERAL DIRECTOR (NAME) Engelage Funeral Home
(ADDRESS) Sarcoxie, Missouri

20. FILED 5/17 39

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15, 39 19

22. I HEREBY CERTIFY, That I attended deceased from 4-20, 1939, to 5-15, 1939.

I last saw h alive on 5-8, 1939. Death is said to have occurred on the date stated above, at 7:30 P.M.
The principal cause of death and related causes of importance were as follows:

Chr cardiac asthma
about 8 mo.

Date of onset

Other contributory causes of importance:

myocarditis
few weeks.

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) W. J. [Signature], M. D.
(Address) Sarcoxie, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1139

Date Filed JUN 2 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me; and

Roland C. Engelage

Registered Apprentice No.

working under my personal supervision.

Signed

Geo B. Orr

Licensed Embalmer No. 946

P. O. Address Mt. Vernon, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

18935- Do not use this space.

1. PLACE OF DEATH (a) County Jasper, (b) Township Sarcopie, (c) City Sarcopie, (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds. 2. PRINT FULL NAME James W. Wallace (a) Residence, No. (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS 3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Wallace 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-3-1861 7. AGE YEARS 78 MONTHS 1 DAYS 12 If LESS than 1 day, hrs. or min. 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter 9. Industry or business in which work was done, as 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) Des Moines Iowa 13. NAME James Wallace 14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Des Moines Iowa 15. MAIDEN NAME unknown 16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) 17. INFORMANT (ADDRESS) Mrs. Madred Wallace Sarcopie Mo 18. BURIAL, CREMATION, OR REMOVAL PLACE Sarcopie Mo DATE 5/17 19. FUNERAL DIRECTOR (ADDRESS) Engelage Funeral Home Sarcopie Mo 20. FILED July 2 1939 Mrs. Emma Broadway Local Registrar.

MEDICAL CERTIFICATE OF DEATH 21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-15-1939 22. I HEREBY CERTIFY, That I attended deceased from 4-22-1939 to 5-15-1939 I last saw him alive on 5-15-1939, 1939. Death is said to have occurred on the date stated above, at 7:30 p.m. The principal cause of death and related causes of importance were as follows: Chronic Cardiac Asthma about 8 months Other contributory causes of importance: Myo Carditis few weeks 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 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) W.B. York M. D. (Address) Sarcopie Mo

