

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29859

State File No. _____

Registration District No. 830

Primary Registration District No. 4503

Registrar's No. 27

1. PLACE OF DEATH

(a) County Shelby
(b) City or town Shelbyville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 60 years
years, months or days

3. (a) PRINT FULL NAME Jane M. Wallace

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive 14 years

7. Birth date of deceased August 14, 1840
(Month) (Day) (Year)

8. AGE: Years 100 Months 0 Days 0 If less than one day hr. 1 min. 0

9. Birthplace Shelbyville Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Not Known 9

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Agnes Richards

(b) Address Shelbyville, Mo

17. (a) Buried (b) Date thereof 8-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbyville, Mo

18. (a) Signature of funeral director William Barker

(b) Address Shelbyville, Mo

19. (a) Aug 17 - 1940 (b) Ruth Joyner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby

(c) City or town Shelbyville
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 14
year 1940 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from 7-4 to 8-10-40, 19____;
that I last saw her alive on 8-10-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration 3 hrs

Infection from Bedsores
Due to General debility

Due to 100 years.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 749

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. M. Wood (M. D. or other) 1

Address Shelbyville Date signed 8-17-40

RECEIVED

District Health Officer No. 10

District File Number 9-40-1786

Date Filed SEP 18 1940

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, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Harry A. Backelee

Licensed Embalmer No.

3835

P. O. Address

Sheelbun, Mo.

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.