FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31105

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3668

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-13-40-9-15-40 (Specify whether In this community 10 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1416 E. 24th St. (If rural, give location)

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

3. (a) PRINT FULL NAME Goldie Bessie Wallace

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 12 (Month) 18 (Day) 1921 (Year)

8. AGE: Years 18 Months 8 Days 28 If less than one day ..... hr. ..... min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Richard Wallace
13. Birthplace ..... (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Juanita Younge
15. Birthplace ..... (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-40 (Month) (Day) (Year)

(c) Place: burial or cremation West Lawn

18. (a) Signature of funeral director Mrs. J. W. Jones

(b) Address 440 State Line K.C.R. K.C. Emb. & Casket Co.

19. (a) 9-19-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 14 year 40 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from 8-13-, 1940 to 9-14-, 1940 that I last saw her alive on 9-14-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Post Operative Peritonitis	
Due to Intestinal Obstruction	
Due to	
Other conditions (Include pregnancy within 3 months of death) 1221	

Major findings:
Of operations Sterilization because of mental debility 8/14/40
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 9-16-40

(Licensed Embalmer's Statement on Reverse Side)

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

Signed Eugene English

Licensed Embalmer No. 4105

P. O. Address K. C. Kansas

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

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