

Registration District No. 318

Primary Registration District No. 5439

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

PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: Springfield R.F.D. # 11  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 10 years 2

3. (a) PRINT FULL NAME WALLACE VINCENT IRVINE

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary L. Irvine 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased June 19 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 17 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name William B. Irving

13. Birthplace Unknown Canada  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Jones

15. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. V. Irving

(b) Address 2702 W. Calhoun Sp. Mo.

17. (a) Burial (b) Date thereof Nov. 8 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Camp Ground

18. (a) Signature of funeral director B. C. Glendon

(b) Address Springfield, Mo.

19. (a) 11-8-40 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 2702 W. Calhoun Rt. # 11  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6  
year 1940 hour 11:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Sept \_\_\_\_\_, 1937, to Nov 6 \_\_\_\_\_, 1940;  
that I last saw him alive on Nov 5 \_\_\_\_\_, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis (Chronic Fibroid)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature R. M. White (M. D. or other) \_\_\_\_\_  
Address Springfield Mo Date signed 11-11-40

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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**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 *R. H. Thomas*.....

Licensed Embalmer No. 3681.....

P. O. Address Springfield, 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, fact should be so stated above.**

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