

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1002

41410

State File No.

4803

JAN 10 1941

399

Registration District No.

Primary Registration District No.

Registrar's No.

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: K.C. Municipal Tbc Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 Mos  
(Specify whether  
In this community Unknown  
years, months or days)

8. (a) PRINT FULL NAME John Wallace

8. (b) If veteran, No name war No  
8. (c) Social Security No. 463-09-2578

4. Sex M 5. Color or race W  
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 Feb 17 1884  
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 23  
If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Writer

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

MOTHER FATHER { 12. Name John Wallace  
13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Goldthida Lee  
15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature K.C. Municipal Tbc Hosp  
(b) Address Leeds Station

17. (a) Removal (b) Date thereof 12-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Walter Funeral Home  
(b) Address 2332 Monitor Place, K. C. Mo

19. (a) 12-17-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 603 Main  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9<sup>th</sup>  
year 1940 hour 7:15 minute P M.

21. I hereby certify that I attended the deceased from June 11, 1940 to Dec 9, 1940;  
that I last saw him alive on Dec 9, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tbc  
Due to 213  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
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? 361  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Walter (M. D. or other) \_\_\_\_\_  
Address K.C. Tbc Hospital Date signed \_\_\_\_\_

**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 \_\_\_\_\_,

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

Signed \_\_\_\_\_

L. Blaine E. Waitent  
Licensed Embalmer No. 4075

P. O. Address 2332 Monitor Pl.

**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.**