

MAR 19 1942
Registration District No. 149

Primary Registration District No.

5692 Registrar's No.

1. PLACE OF DEATH:

- (a) County McDonald
(b) City or town Goodman
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1000
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether

In this community
years, months or days)3. (a) PRINT
FULL NAMEMary Wallace

3. (b) If veteran,

name war

3. (c) Social Security

No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married
divorced married

6. (b) Name of husband or wife

Andrew Wallace 6. (c) Age of husband or wife ifalive 64 years7. Birth date of deceased June 15 - 1865

(Month)

(Day)

(Year)

8. AGE: Years Months Days If less than one day

75 72 7 24 hr min.

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

10. Usual occupation Housekeeper

11. Industry or business

12. Name John Carter

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

14. Maiden name Unknown

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

16. (a) Informant Andrew Wallace(b) Address Goodman17. (a) Burial (b) Date thereof 2-17-41

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howard Cemetery18. (a) Signature of funeral director Charles Williams(b) Address Goodman19. (a) 2-10-41 (b) Charles Williams

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County McDonald
(c) City or town Goodman
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16
year 1941 hour 12 minute 20 p.m.21. I hereby certify that I attended the deceased from
19 to 19

that I last saw h. alive on 19

and that death occurred on the date and hour stated above.

Immediate cause of death No. 1. Dilationcalled the death ofinfluenzaDue to SameLong days ofDue to Charles WilliamsOther conditions None

(Include pregnancy within 6 months of death)

Major findings: None

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

RECEIVED

District _____ Calover No. 8,

District No. _____

Date Filed _____

541-475
MAR 17 1947

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7522

Registration District No. 142

Primary Registration District No. 5693

Registrar's No. _____

PLACE OF DEATH:

- (a) County McDonald
(b) City or town Erie, Pa.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

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

- (d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT
FULL NAME

Mary Wallace

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if
alive _____ years

7. Birth date of deceased June 18 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 24 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

- (b) Address _____

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

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 5/10/4 (b) Chas. W. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____
(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 Feb day 16
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

- that I last saw him _____ alive on _____, 19____;

- and that death occurred on the date and hour stated above.

- Immediate cause of death _____

- Due to This woman had a lingering illness for several weeks.

- Due to No phy. called.

- 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? _____

- While at work? _____ (Specify type of place)

- (e) Means of injury _____

23. Signature _____ (M. D. or other)

- Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

