

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41181**
Registrar's No. **4862**

Registration District No. **257**

Primary Registration District No. **1002**

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: **St Marys Hospital.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Days**
(Specify whether
in this community **10 Yrs.**
years, months or days)

3. (a) PRINT FULL NAME **Mabel Wallace**

3. (b) If veteran, name war **700** 3. (c) Social Security No. **700**

4. Sex **Female** 5. Color or race **Wht** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Chas. E. Wallace** 6. (c) Age of husband or wife **49** years
7. Birth date of deceased **Jan. 6 1903**
(Month) (Day) (Year)

8. AGE: Years **38** Months **II** Days **20** If less than one day .hr. .min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Pete Ahlstorm**

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

14. Maiden name **Anna Dilkson**

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

16. (a) Informant **Chas E Wallace**

(b) Address **1415 So 38th To B 764**

17. (a) **Removal** (b) Date thereof **12/29/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Reaching Kansas**

18. (a) Signature of funeral director **Simmons & Horn**

(b) Address **15 C. St.**

19. (a) **Dec 29 1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Wyandotte**
(c) City or town **Kansas City, Kan.**
(If outside city or town limits, write "RURAL")
(d) Street No. **1415 So 38th**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **26**
year **1941** hour **10** minute **15 PM.**

21. I hereby certify that I attended the deceased from **June 19, 1941** to **Dec. 26, 1941**
that I last saw her alive on **Dec. 26, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Sub-acute glomerular nephritis acute upper respiratory infection**
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **1318**
Of autopsy **same as above**

Duration

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?

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

23. Signature **Chas E Wallace** (M. D. or other)
Address **3118 1/2 St. N. W.** Date signed **12/27/41**

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

838

JUN 25 1957

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.....

H. Simmons

Licensed Embalmer No. *3903*

P. O. Address. *1404 437 KB*

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.