

FILED FEB 16 1942
126

Registration District No. _____

Primary Registration District No. 4432-5757 Registrar's No. 201

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Rural
(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 Martha Jane 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, widow 2

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

7. Birth date of deceased October 14th 1856
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name William Evans

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

14. Maiden name Martha J. Clayton

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

16. (a) Informant Mrs. W. C. Watson

(b) Address New London, Missouri

17. (a) Burial (b) Date thereof Nov. 26, '41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barkley Cemetery

18. (a) Signature of funeral director O'Donnell Funeral Home

(b) Address New London, Missouri

19. (a) _____ (b) R. S. Binkley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls
(c) City or town Rural
(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 November day 25th
year 1941 hour 4:00 minute A M.

21. I hereby certify that I attended the deceased from 2-28- 1940, to 11-25- 1941.

that I last saw her alive on Nov. 20, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes

Due to _____

Due to _____

Other conditions Broken hip
(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 087

(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. J. Waters (M. D. or other) _____

Address New London, Mo Date signed _____

RECEIVED

District Health Officer No. 10

District File Number

2-42-235

Date Filed FEB 12 1942

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.....

Michael J. O'Donnell

Licensed Embalmer No. 3246

P. O. Address Hannibal, Missouri.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3281**

Registration District No. **726**

Primary Registration District No. **5957**

Registrar's No.

1. PLACE OF DEATH:

- (a) County **Ralls**
(b) City or town **Rural**
(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 **Martha J. 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 **W**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct 14** (Month) (Day) (Year)

8. AGE: **85** Years Months Days (if less than one year) 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

- Due to **Broken Hip**
Fall at home
2-28-1940
Due to _____

- 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?

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

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

- Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

