

FILED MAY 20 1943

Registration District No.

Primary Registration District No. 5411

Registrar's No. 21

1. PLACE OF DEATH:

(a) County FRANKLIN
(b) City or town GRAY SUMMIT MO.
(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 16 YEARS
years, months or days

3. (a) PRINT FULL NAME FRANCES HENRIETTA WALLACE

3. (b) If veteran, name was NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EDWARD WALLACE 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased OCTOBER 18 1898
(Month) (Day) (Year)

8. AGE: Years 43 Months 5 Days 21 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

12. Name HERMAN LEMM

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

14. Maiden name BERCHA WILSON

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

16. (a) Informant Ed Wallau

(b) Address GRAY SUMMIT MO.

17. (a) BURIAL (b) Date thereof 4/12/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gray Summit Mo.

18. (a) Signature of funeral director And. L. Shikes

(b) Address Pacific Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County FRANKLIN
(c) City or town GRAY SUMMIT
(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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 9
year 1942 hour 11 minute 5 A. M.

21. I hereby certify that I attended the deceased from JULY 15 1941 to APR 9 1942
that I last saw her alive on APR 9 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Lung
Due to

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?

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

23. Signature W. H. Stender (M. D. or other)

Address Pacific Mo. Date signed 4/19/42

Duration

4 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Geo L. Shikes

Licensed Embalmer No. *3008*

P. O. Address *Pacific, 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.

STANDARD CERTIFICATE OF DEATH

State File No. 14 282
Registrar's No. 21

Registration District No. 293 Primary Registration District No. 5411

1. PLACE OF DEATH:

- (a) County Franklin
(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 Frances H 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 Oct 18 (Month) (Day) (Year)

8. AGE: Years 43 Months 5 Days 20 (If less than one day, in min.)

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 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) 4/10/42 (b) Blanch C. Fletcher
(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 Apr year 1942 hour _____ minute _____ M.

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

- Due to _____

- 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? _____

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

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

- Address _____ Date signed _____

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

SUPPLEMENTARY

