

S. No. 1-4-41  
17-39  
X26390

Dr. Fitch 25003

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

REC. AUG 9 1943

Registration District No. 128

Primary Registration District No. 2200

Registrar's No. 594

1. PLACE OF DEATH: GREENE

(a) County GREENE

(b) City or town Thomas Benjamin Wallace  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
401 1/2 West Elm /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Several Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 31

(a) State Missouri (b) County Greene 2

(c) City or town Springfield, Mo. 6  
(If outside city or town limits, write "RURAL")

(d) Street No. 401 1/2 W. Elm St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Benjamin Wallace

3. (b) If veteran, name war No

3. (c) Social Security No. Unk.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced, widower 2

6. (b) Name of husband or wife Unk.

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased August 25th 1877  
(Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	65	10	28	hr. min.

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

10. Usual occupation Carpenter

11. Industry or business -----

MOTHER FATHER

12. Name Franklin Wallace

13. Birthplace Unk Illinois 1 Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Page

15. Birthplace Unk. 1 Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Pete Wallace  
(b) Address 706 E. Dale

17. (a) Burial (Burial, cremation, or removal)  
(b) Date thereof July 30, 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Wallace Cemetery

18. (a) Signature of funeral director W.L. Dunn  
(b) Address 629 W. Walnut, Springfield, Mo.

19. (a) 7-28-43 (b) W. W. Haugh  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1943 hour 10 minute -- A. M.

21. I hereby certify that I attended the deceased from  
from 1 1943 July 23 1943  
that I last saw him alive on July 23 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Cardio-renal - Uncon-  
sciousness

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Fracture of Left Hip 4 Weeks  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration 1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  133

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

23. 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)

23. Signature Max Fitch (M. D. or other)  M.D.  
Address Springfield Mo. Date signed 7-27-43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING 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 *Charles J. McCracken*

Licensed Embalmer No.....

P. O. Address.....

*28911*

*X*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Hanna  
(b) City or town \_\_\_\_\_  
(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)

Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Thomas Benjamin Wallace

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 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 \_\_\_\_\_ year

7. Birth date of deceased Aug 25 (Month) (Day) (Year)

8. Age at death: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) M. W. Handley (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 July 1943 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 Cardiac Renal

Vascular Disease

\_\_\_\_\_

\_\_\_\_\_

Due to \_\_\_\_\_

\_\_\_\_\_

Due to \_\_\_\_\_

\_\_\_\_\_

Other conditions Fracture of left hip

(Include pregnancy within 3 months of death)

\_\_\_\_\_

Major findings: See

Of operations \_\_\_\_\_

\_\_\_\_\_

Of autopsy \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 6-26-43

(c) Where did injury occur? Spring Lake, Greer, Mo. (City) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place) (e) Means of injury Fall

\_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WRITE PLAINLY—USE UNFAINT BLANK INCREASE IN LENGTH OF RECORD

SUPPLEMENTAL

INTERVIEW

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

