

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 17 1943

Registration District No. 374

Primary Registration District No. 6274 4549

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Worth, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community 73 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Aden Holiday Wallace

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

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Carroll Owens 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased April 26 1862
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 5 If less than one day
hr. min.

9. Birthplace Ontario Canada 2
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name John Wallace

13. Birthplace Canada 2
(City, town, or county) (State or foreign country)

14. Maiden name Ann Holiday

15. Birthplace Scotland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Isabel Wallace
(b) Address St Joseph, Mo

17. (a) Burial (b) Date thereof July 3-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Ways Andrews
(b) Address 2 North 3rd

19. (a) July 5-1943 (b) Ailene Scadden
(Date received local registrar) (registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1943 hour 3:00 minute 0 M.

21. I hereby certify that I attended the deceased from June 10
1943, to June 28, 1943;
that I last saw him alive on June 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Duration 3 days

Due to 108

Other conditions Old age
(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?

While at work (Specify type of place) (c) Means of injury fall

23. Signature Charles H. Williamson (M.D. or other) MD
Address Neustey Mo Date signed 7-2-43

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

113
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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..... *Hayes Andrews*

Licensed Embalmer No.....

P. O. Address..... *North, 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.