

Registration District No. 33128 Primary Registration District No. 2000

1. PLACE OF DEATH:  
**GREENE**  
(a) County  
(b) City or town **Springfield,**  
(c) Name of hospital or institution:  
**1345 Washington Ave. /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
In this community **None**  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Christian**  
(c) City or town **Billings**  
(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

3. (a) PRINT FULL NAME **Isabelle M. Wallace**  
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **February** day **23rd**  
year **1944** hour **3:15** minute **A. M.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **A. S. Wallace** 6. (c) Age of husband or wife if alive **Unknown** years  
7. Birth date of deceased **February 11, 1869**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 15, 1944** to **Feb. 23, 1944**  
that I last saw her live on **Feb. 23, 1944**  
and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **0** Days **12** If less than one day hr. min.

Immediate cause of death **Cerebral hemorrhage 8 days**  
Due to **Chr. degenerative car- dio-vascular dis.**  
Due to

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

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

10. Usual occupation **Housewife**  
11. Industry or business **In Home**

MOTHER FATHER { 12. Name **John Amsler**  
13. Birthplace **Unknown Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sarah Ault**  
15. Birthplace **Unknown Pennsylvania**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
**939**

16. (a) Informant **Mr. A. S. Wallace**  
(b) Address **Billings, Missouri**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence

17. (a) **Burial** (b) Date thereof **2/25/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Rosehill Cemetery**

(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)

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**  
(b) Address **Springfield, Missouri**

While at work? (Specify type of place) (c) Means of injury  
23. Signature **Arthur G. Smith** M. D. or other  
Address **Springfield, Mo.** Date signed **2-25-44**

19. (a) **2-25-44** (b) **A. W. Handley**  
(Date received local registrar) (Registrar's signature)

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

9  
2  
6

934

2

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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 *Harlow Knapp*

Licensed Embalmer No. *4065*

P. O. Address. *Springfield, 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.**

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