

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14217

State File No. 395

Registrar's No. 395

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Methodist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs
(Specify whether
In this community 3 yrs
years, months or days)

3. (a) PRINT FULL NAME Rev. John L. 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 Susie 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Dec 23 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 17 If less than one day — hr. — min.

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

10. Usual occupation Minister

11. Industry or business —

12. Name James S Wallace
13. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Margaret J.
15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs J. L. Wallace
(b) Address St Joseph

17. (a) Burial (b) Date thereof 4-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St Joseph, Mo

19. (a) 4/10/44 (b) —
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 3220 Mitchell
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 1944 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from Feb 19 1944 to Apr 9 1944
that I last saw him alive on — 19—;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial 3 days
Due to Coronary Heart Disease with decompensation 3 yrs
Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: Of operations 107
Of autopsy —
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) (e) Means of injury —

23. Signature Dr. D. H. H. H. (M. D. or other) MD
Address St Joseph, MO Date signed 4-10-44

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

1233

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

Robert H. Gaph

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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.