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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAY 25 1944**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17226  
Registrar's No. 2200

Registration District No. 149

Primary Registration District No. 1002

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Children's Mercy Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 1/2 hours  
(Specify whether years, months or days)  
 In this community 3 1/2 hrs.

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Saline  
 (c) City or town Marshall, Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 728 North O'Dell  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Peggy Sue Wallace  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 5-16 day \_\_\_\_\_  
 year 1944 hour 10 minute 55 p. M.  
 21. I hereby certify that I attended the deceased from 5-14-44, 19\_\_\_\_, to 5-16-44, 19\_\_\_\_;

4. Sex female 5. Color or race w  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov 22 1943  
(Month) (Day) (Year)

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death Acute Pharyngitis, Acute laryngitis, Toxemia

**8. AGE:** Years \_\_\_\_\_ Months 6 Days 24  
If less than one day hr. min.

Due to Spina Bifida; Meningo-mylelocele  
 Due to \_\_\_\_\_

9. Birthplace Saline Co Ark MO  
(City, town, or county) (State or foreign country)

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation infant

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 1576

11. Industry or business \_\_\_\_\_

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)

12. Name Wm. Wallace

Did injury occur in or about home, on farm, in industrial place, in public place?  
 (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

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

14. Maiden name Loene

15. Birthplace NO Ark MO  
(City, town, or county) (State or foreign country)

16. (a) Informant S. S. Mc Anself  
 (b) Address 2528 Jackson

17. (a) Removal (b) Date thereof 5-17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director Earl J. Hunt Home  
 (b) Address Mo  
 19. (a) 5-20-44 (b) D. C. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature H. H. H. H. (M. D. or other) \_\_\_\_\_  
 Address 1624 Puff Date signed \_\_\_\_\_

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**