

FILED DEC 13 1944

Registration District No.

Primary Registration District No. 6 114

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Rural *Merley Twp*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1 mile west of Morley
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 30 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott *100*

(c) City or town 1 Mile west of Morley *0*
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) *1*
If yes, name country

3. (a) PRINT FULL NAME William L. Wallace

3. (b) If veteran, name war x 3. (c) Social Security No. none

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bernice Wallace 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased January 7 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>9</u>	<u>0</u> hr. min.

9. Birthplace Boonville Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name John C. Wallace

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

14. Maiden name Unknown

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

16. (a) Informant Dallas Wallace

(b) Address Newton, Mississippi

17. (a) Burial (b) Date thereof 10-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director Orville Taylor

(b) Address Sikeston, Mo.

19. (a) Nov. 20-44 (b) Mrs. Wm Factor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7
year 1944 hour 3 minute 30 p. M.

21. I hereby certify that I attended the deceased from 9/1 to 10/15 1944 and that death occurred on the date and hour stated above.

Immediate cause of death dehydration starvation

Due to Carcinoma jaw

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 450 Of autopsy

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 W.D. ... (M. D. or other) Chaffee Mo Date signed 10/15/44

Duration

14 Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100
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1042

RECEIVED

District Health Office No. 2,

District File Number 1344-1570

Date Filed 12-7-44

1207 U

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 Alfred W. Greer.....

Licensed Embalmer No. 1027.....

P. O. Address Poplar Bluff, 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.