

No. 2  
-5-43  
5-17-39  
I X36671

FILED JAN 26 1945  
149

Registration District No. \_\_\_\_\_

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution:  
709 Washington  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 709 Washington 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 11

3. (a) PRINT FULL NAME Joseph Wallace

3. (b) If veteran, name was No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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: about 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 82 hr. \_\_\_\_\_ min.

9. Birthplace: Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired--12 years

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

12. Name Patrick Wallace

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

14. Maiden name Ann Smith

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

16. (a) Informant Mike B Curry

(b) Address 930 Chest 33rd Terrace

17. (a) Removal (b) Date thereof 1/8/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salina, Kansas

18. (a) Signature of funeral director Timothy P. Brown

(b) Address 20 West Linwood

19. (a) 1-8-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 6  
year 1945 hour 3:35 minute P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to arterio-sclerosis

Due to 940

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

Major findings: History + Injection

Of operations \_\_\_\_\_

Of autopsy not

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 3 Coron

23. Signature James Walker (M. D. or other) 3 Coron

Address 1424 1/2 1st St Date signed 1-7-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

*Maudie Adair*

Licensed Embalmer No. *193174* 4016

P. O. Address *20 W. Lincoln*

**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.**