

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

FILED SEP 8 1945
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26772

State File No. _____

Registration District No. 32

Primary Registration District No. 4-5114

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town near Sissy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Eva Wallace 6. (c) Age of husband or wife if alive 22 years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 59 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Wallace
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Sa Faltwarger
15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Louis Jackson
(b) Address Sissy, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Berrong Cemetery
18. (a) Signature of funeral director Alfred S. Morgan
(b) Address Advance Mo.
19. (a) Aug 21 1945 (Date received local registrar) (b) Mrs. Geneva Graham (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger
(c) City or town near Sissy
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1945 hour 10 minute 0 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 Cerebral hemorrhage
Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

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 3

23. Signature John J. Hyman (Registrar's signature) Date signed 7/31/45
Address St. Louis, Mo.

1063

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 945-103

Date Filed 9-6-45

SUN 23 1947

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.....

Floyd S. Morgan Registered Apprentice No.....
working under my personal supervision.

Signed Floyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept 66
Registrar's No. 66

Registration District No. 32 Primary Registration District No. 5114

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME

Burley Wallace

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (10 30 1945)
(Month) (Day) (Year)

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

59 hr. min.

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

10. Usual occupation Laborer, Timber Camp

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 26
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 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.

Due to. Due to.

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

Major findings: Of operations.

Of autopsy.

PHYSICIAN

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 (M. D. or other) Address Date signed

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

SUPPLEMENTARY

5-26772