

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33065**
Registrar's No. **88**

FILED NOV 8 1945
Registration District No. **27**
Primary Registration District No. **5079**

1. PLACE OF DEATH:

(a) County **Bates**
(b) City or town **Bates**
(c) Name of hospital or institution **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 months**
In this community **4 months**
years, months or days

3. (a) PRINT FULL NAME **MARTHA SUSAN WALLACE**

3. (b) If veteran, name war. **1** 3. (c) Social Security No. **1**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **1** 6. (c) Age of husband or wife if alive **1** years

7. Birth date of deceased **JULY 12 - 1864**
(Month) (Day) (Year)

8. AGE: Years **81** Months **3** Days **9** If less than one day hr. min.

9. Birthplace **Odesa Mo - 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **1**

12. Name **Joshua Wallace**

13. Birthplace **1**
(City, town, or county) (State or foreign country)

14. Maiden name **1**

15. Birthplace **Odesa Mo - 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **1**

(b) Address **Butler # 6 -**

17. (a) **1** (b) Date thereof **10-23-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bates City Mo**

18. (a) Signature of funeral director **1**

(b) Address **Odesa**

19. (a) **10-23-45** (b) **1**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **BATES**
(c) City or town **rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **deep water Swamp**
(If rural, give location)
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT** - day **2**
year **1945** hour **11** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **1** to **1**

that I last saw him alive on **1** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **1**

Due to **1**

Other conditions **1**
(Include pregnancy within 3 months of death)

Major findings: **1**
Of operations **1**

Of autopsy **1**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **1**

(b) Date of occurrence **1**

(c) Where did injury occur? **1**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **1**

PHYSICIAN

Underline the cause to which death should be charged statistically.

While at work **1** (Specify type of place) (c) Means of injury **1**

23. Signature **1** (M. D. or other) **1**

Address **Butler Mo - 1** Date signed **1**

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 _____

Horace Bluminc

Licensed Embalmer No. *2758*

P. O. Address *Odessa Fla*

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 88

Registration District No. 27

Primary Registration District No. 5079

1. PLACE OF DEATH: Baten
(a) County Rural Charlotte Twp.
(b) City or town (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 Martha S. Wallace
3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife alive 6. (c) Age of husband or wife if 2
7. Birth date of deceased July (Month) 2 (Day) 1945 (Year)

8. AGE: Years 81 Months 3 Day min. If less than one day

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

10. Usual occupation

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) Kendall Perry (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 Dec Year 1945 Hour 1 Minute M.
21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him live on and that death occurred on the date and hour stated above. Immediate cause of death Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

MOTHER FATHER

33065