

FILED DEC 3 1945
Registration District No. **256**

Primary Registration District No. **256**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St Johns Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **27 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Joplin**
(If outside city or town limits, write "RURAL")
(d) Street No. **406 S. Cox**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Emma M Wallace**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **W. M. Wallace** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **September 23, 1879**
(Month) (Day) (Year)

8. AGE: Years **66** Months **1** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **Hamblin W. Virginia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Hargus A Duke**
13. Birthplace **West Virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Powell**
15. Birthplace **West Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. M. Wallace**
(b) Address **406 S. Cox, Joplin, Mo**
17. (a) **Burial** (b) Date thereof **10-29-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ozark Memorial**

18. (a) Signature of funeral director **PARKER-HUNSAKER**
(b) Address **1502 Joplin, Joplin, Mo**
19. (a) **10-20-45** (b) **Ed Jones**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **26**
year **1945** hour **2** minute **4** A.M.

21. I hereby certify that I attended the deceased from **July 4 - 45**, 19, to **Oct 26 - 45**, 19;
that I last saw her alive on **Oct 25 - 1945**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Ext cerebral Hemorrhage - First on July 4, 1945**
Duration **Sept 10-21-45**
Due to **Chronic Hypertension** **5-20-44**

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

Major findings: Of operations _____
Of autopsy **130**
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 **Walter Hymas** (M. D. or other) **W**
Address **Joplin Mo** Date signed **10/27/45**

45-11-883

DEC-5-1955

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 F M Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.