

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12240

State File No.

FILED APR 9 1947
Registration District No. 320

Primary Registration District No. 6225

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Nevada (Wash Township)
(c) Name of hospital or institution: State Hospital 3-2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo. 11 days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME LONNIE-WALLACE

3. (b) If veteran, name war no 8. (c) Social Security No. none

4. Sex male 5. Color or race wh. 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive years

7. Birth date of deceased July 28 1897
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 2 If less than one day - hr. - min.

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

10. Usual occupation none

11. Industry or business none

MOTHER FATHER { 12. Name John Wallace
13. Birthplace unknown unknown
(City, town, or county) (State or foreign country)
14. Maiden name Addie Miller
15. Birthplace unknown Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Records of State Hosp 3
(b) Address Nevada Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Apr 9 1947
(Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Alfred R. Rouse
(b) Address Nevada Mo

19. (a) 4-2-47 (b) Hathorn
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 512 Woodland
(If rural, give location)
(e) If foreign born, how long in U. S. A. no years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1947 hour 10 minute 50A M.

21. I hereby certify that I attended the deceased from Dec 19 1946 to March 30 1947
that I last saw him alive on March 30 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
Due to Hypertension, arteriosclerosis, aortic stenosis
Due to none

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy findings as above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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 0

23. Signature Paul L. Barone (M. D. or other)
Address State Hosp 3 Date signed April

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

RECEIVED
District Health Officer No. 7,
District File Number 4-8-47
Date Filed 3-47-394

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 Allen S. Kays
Licensed Embalmer No. 1968
P. O. Address Nevada, 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, above space should be left blank.