

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16756

State File No. _____

Registration District No. 47

Primary Registration District No. 5168

Registrar's No. 189

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town 6-1/2 N Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCredie
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether)
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Martin Bailey Wallace

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hettie Wallace 6. (c) Age of husband or wife if alive 2 years 1887

7. Birth date of deceased April (Month) 2 (Day) 1887 (Year)

8. AGE: Years 60 Months 1 Days 18 If less than one day hr. _____ min. _____

9. Birthplace 6 1/2 Mi N Fulton (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Joseph W. Wallace

13. Birthplace Kentucky

14. Maiden name Virginia Bell Craig

15. Birthplace Missouri

16. (a) Informant Leo G. Wallace

(b) Address Fulton, Missouri

17. (a) Burial (b) Date thereof 5-22-47

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richland Baptist Ch Cem

18. (a) Signature of funeral director Wallace Funeral Home

(b) Address 7 W 6th St Fulton, Missouri

19. (a) 5-22-1947 (b) Joiee M. Smith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month 20 day May
year 1947 hour 5 minute 30 AM.

21. I hereby certify that I attended the deceased from Feb - 1, 1947, to May - 20, 1947.
that I last saw him alive on Apr - 25, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94A

Major findings: Of operations none

Of autopsy none

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)

Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? (Specify type of place) (c) Means of injury _____

23. Signature J. C. Suggitt (M. D. or other) M.D.

Address Columbia, Mo Date signed 5-21-47

RECEIVED
District Health Officer No. _____
District File Number _____
Date Filed 5-27-47

DEC 2 1954

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 Denzil C. Browning
Licensed Embalmer No. 2724
P. O. Address Fullton md

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.