

FILED SEP 18 1947

Registration District No. 37

Primary Registration District No.

6075

Registrar's No.

306

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 mos. 14 das.  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME JERRY FRANKLIN WALLACE

3. (b) If veteran, name war Unknown 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced or Widowed  
(b) Name of husband or wife Rose Stubblefield 6. (c) Age of husband or wife if alive, years 4  
7. Birth date of deceased March 4, 1871  
(Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name William Wallace

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

14. Maiden name Sarah Leslie

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 8-6-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lightner Cem., Illmo, Mo.

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

(b) Address Chaffee, Missouri

19. (a) 9-9-47 (b) Esther Rudloff  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott  
(c) City or town Illmo RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route #1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3,  
year 1947 hour 11 minute 50 P. M.

21. I hereby certify that I attended the deceased from January 21, 1947 to August 3, 1947,  
that I last saw him alive on August 3, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Inter cerebral

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy No 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?

(Specify type of place) While at work (e) Means of injury

23. Signature Gorge K. Reuro (M. D. or other)

Address Farmington Mo. Date signed 8-7-47

RECEIVED

Health Officer No. 4  
District File Number 947-118.4  
Date Filed 9-16-47

SEP 25 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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Paul K. Dwyer  
Licensed Embalmer No. 4120  
P. O. Address Farmington 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.