

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

1471

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 3 1948

Registration District No. 146

Primary Registration District No. 5368

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Jackson Rural
(b) City or town Kansas City Blue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8712 Independence Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 4 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City Rural 3
(If outside city or town limits, write "RURAL")
(d) Street No. 8712 Independence Ave. 3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY WALLACE

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

4. Sex fe 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 27 1889
(Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Webster City IOWA 1
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse-Retired

11. Industry or business Ellsworth Hospital Iowa

12. Name Joseph Wallace

13. Birthplace Scotland 4
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Hoag

15. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Warren L. Davis

(b) Address 440 Blue Ridge

17. (a) Burial (b) Date thereof Jan 9 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd. N.C. Mo

19. (a) 1-9-48 (b) [Signature]
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January Day 7
year 1948 hour 8 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis Duration _____

Due to _____
Due to Reputy Coroner

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

Major findings: History of Inspection PHYSICIAN _____
Of operations _____
Of autopsy _____
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 A.E. Upsher (M. D. or other) _____

Address 2800 Main Date signed 1/9/48

(Licensed Embalmer's Statement on Reverse Side)

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

48
0
0

MOTHER FATHER

FEB 23 1945

FEB 4 1945

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 O. K. McFarland

Licensed Embalmer No. 4397

P. O. Address Kansas City 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.