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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 15 1948

Registration District No. 184

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

16884

State File No. ....

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
524 N. Main St. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Mo. Linn 58  
(a) State Mo. Linn 58  
(b) City or town Brookfield 1  
(c) City or town Brookfield (If outside city or town limits, write "RURAL") 2  
(d) Street No. 524 N. Main St. 0  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Charles Robert Wallace

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

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced. /

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

7. Birth date of deceased December 22, 1862 (Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Muscatine Iowa (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Chas. Robert Wallace  
13. Birthplace Muscatine Iowa /  
14. Maiden name Mary Laneing (State or foreign country)  
15. Birthplace Madison Wisc / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eleanor Wallace  
(b) Address Brookfield, Mo.

17. (a) Burial (b) Date thereof May 29, 1948 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Michael

18. (a) Signature of funeral director Bowden Funeral Home  
(b) Address Brookfield, Mo.

19. (a) 5-29-48 (b) Waterbury (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1948 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from May 18 1948 to May 26, 1948 that I last saw him alive on May 26, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Coronary sdg. Due to: Chronic Coronary sdg. and Myocardial infarction.

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

Major findings: Of operations: 131B

Of 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?

23. Signature: [Signature] (M. D. or other) Date signed: 5/29/48

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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

*Jamer B McCallum*

Licensed Embalmer No.

*4230*

P. O. Address

*Brookfield, 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.