

Registration District No. 207 Primary Registration District No. 4319 Registrar's No. 20

1. PLACE OF DEATH:  
(a) County Warren  
(b) City or town Belle  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Warren 6 3 3  
(c) City or town Belle 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edward Augustus Wallace  
(b) If veteran, name war ✓  
(c) Social Security No. ✓

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 5  
year 1948 hour 5 minute 10 P.M.  
21. I hereby certify that I attended the deceased from 3/25/48 to 7/5/48, 19...  
that I last saw him alive on 7/4/48, 19...  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Augusta Wallace  
(c) Age of husband or wife if alive 71 years  
7. Birth date of deceased Sept 24 1870  
(Month) (Day) (Year)

Immediate cause of death Bronchial Pneumonia Duration 36 hrs  
Due to Diabetes Mellitus  
Due to Chronic Nephritis 3 yrs  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day min.  
77 9 11 \_\_\_\_\_ min.  
9. Birthplace Belle Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired

PHYSICIAN  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 61  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business ✓  
12. Name Barney Wallace  
13. Birthplace Tenn. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Josephine Dessioy  
15. Birthplace O.Sage Missouri  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant J. J. Burdson  
(b) Address Belle, Mo.  
17. (a) Burial (b) Date thereof 7-6-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Liberty - Belle, Mo.  
18. (a) Signified by Pauline Howard  
(b) Address Belle, Mo.  
19. (a) 7-8-48 (b) Pauline Howard  
(Date received local registrar) (Registrar's signature)

23. Signature: R. H. Schenkels (M. D. or other) Dr.  
Address: Belle, Mo. Date signed: 7/7/48  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 2

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed  
JUL 15 1948

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

*Arthur Roseberry*

Licensed Embalmer No.

4178

P. O. Address

Bland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.