

E. No. 300  
M-10-47  
v. 5-17-39  
I 966

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40401

FILED DEC 29 1948

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5154

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
3839 Montgall  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X  
In this community 28 Years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 3839 Montgall  
(If rural, give location)

(e) Citizen of foreign country? X no (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Mary Ann Wallace

(b) If veteran, name war X

(c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16  
year 1948 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from Twenty five years  
19 to Dec 15 1948  
that I last saw him alive on 6-15-1948  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color of race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John W. Wallace

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased Jan. 17, 1859  
(Month) (Day) (Year)

Immediate cause of death Lobar Pneumonia

Due to Senile

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

89 210 229 hr. min.

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

10. Usual occupation Home

Major findings: Of operations 1-2-8

Of autopsy No

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Albert Burgett

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

14. Maiden name Sarah Winner

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

16. (a) Informant Miss Effie Wallace

(b) Address 3839 Montgall

17. (a) Burial (b) Date thereof 12-18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director STINE & McCLURE

(b) Address 3235 GILLHAM PLAZA

19. (a) 12-18-48 Steraldine Holmes  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

James T. Ferguson (Specify type of place)  
While at work \_\_\_\_\_ (c) Means of injury

23. Signature James T. Ferguson (M. D. or other)  
Address Springfield, Mo. Date signed 12/17/48

Fun. Jers. P. Frangoniam  
13001 2nd St. Bldg.  
Sp. 13-10

**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 Robert H Reed  
Licensed Embalmer No. 3745  
P. O. Address H. E. Co

**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.**