

FILED MAY 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15406**
Registrar's No. **28**

BIRTH NO. _____		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 1379		Registrar's No. 28	
1. PLACE OF DEATH a. COUNTY DeKalb				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY DeKalb			
b. CITY OR TOWN Rural Sherman, Stewartsville		c. LENGTH OF STAY (In this place) Life		c. CITY OR TOWN Rural Sherman, Stewartsville			
d. FULL NAME OF HOSPITAL OR INSTITUTION Home				d. STREET ADDRESS 8 Mi. N.E. of Stewartsville			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) Andrew		c. (Last) Wallace		4. DATE OF DEATH (Month) (Day) (Year) May 18 49	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 3-12-1895		9. AGE (In years last birthday) 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Wiley Wallace		13b. MOTHER'S MAIDEN NAME Mary Bauer		14. NAME OF HUSBAND OR WIFE Paralee Wallace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME James Wallace Stewartsville Mo ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis of heart ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 734B	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M. S. Galt M.D. Coroner		23b. ADDRESS O s born vna.				23c. DATE SIGNED May-12-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 5-14-49		24c. NAME OF CEMETERY OR CREMATORY Amity		24d. LOCATION (City, town, or county) (State) Amity Mo.	
DATE REC'D BY LOCAL REG. 5-18-49		REGISTRAR'S SIGNATURE Roscoe Davidson		25. FUNERAL DIRECTOR'S SIGNATURE John Brown Mayfield ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3933

P. O. Address Mayville, W.

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.