No. 300
10.48

FILED SEP 26 1949

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 29491

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 313

**1. PLACE OF DEATH**
a. COUNTY: Callaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1211 Westminster

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Callaway
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
d. STREET ADDRESS (If rural, give location): 0

**3. NAME OF DECEASED** (Type or Print)
a. (First): James
b. (Middle): W.
c. (Last): Wallace

**4. DATE OF DEATH** (Month) (Day) (Year): Sept. 13 1949

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): widowed
**8. DATE OF BIRTH**: Feb. 17, 1887
**9. AGE** (In years last birthday): 62 — IF UNDER 1 YEAR: Months 6, Days 26 — IF UNDER 24 HRS.: Hours, Min.
**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Farmer
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (State or foreign country): Mineola, Missouri
**12. CITIZEN OF WHAT COUNTRY?**: U.S.
**13a. FATHER'S NAME**: Jack Wallace
**13b. MOTHER'S MAIDEN NAME**: D.K.
**14. NAME OF HUSBAND OR WIFE**: deceased
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown):
(If yes, give war or dates of service): —
**16. SOCIAL SECURITY NO.**: —
**17. INFORMANT'S SIGNATURE OR NAME**: John Wallace, ADDRESS: Fulton, Mo.

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Abscess — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary heart condition
DUE TO (c) Arterio sclerosis

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*
Epilepsy; 4201

**19a. DATE OF OPERATION**:
**19b. MAJOR FINDINGS OF OPERATION**:
**20. AUTOPSY?** YES ☐ NO ☑

**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) m.:
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**:

22. *I hereby certify that I attended the deceased from* July 27, 1949, *to* Sept 13, 1949, *that I last saw the deceased alive on* Sept 9, 1949, *and that death occurred at* a. m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): R. M. Reeves M.D.
**23b. ADDRESS**: 612 Court St. Fulton Mo
**23c. DATE SIGNED**: 9/13/49

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: Sept. 15, 1949
**24c. NAME OF CEMETERY OR CREMATORY**: Prospect Cem.
**24d. LOCATION** (City, town, or county) (State): 2 mi E. New Bloomfield, Mo.

**DATE REC'D BY LOCAL REG.**: Sept. 13, 1949
**REGISTRAR'S SIGNATURE**: Maretta Laurence by RMO
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Wallace Funeral Home Fulton, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED SEP 20 1949
District Health Officer No. 9,
District File Number----------

## 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.....

P. O. Address.....

**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.**