

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 869
Registrar's No. 73

BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield,
c. LENGTH OF STAY (in this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION 1817 N. National

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield,
d. STREET ADDRESS (If rural, give location) 1817 N. National

3. NAME OF DECEASED
(Type or Print) a. (First) William b. (Middle) Murrell c. (Last) Wallace

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 23, 1950

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH March 19, 1905

9. AGE (In years last birthday) 44 IF UNDER 1 YEAR Months 10 Days 4 IF UNDER 24 HRS. Hours 4 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Produce handler

10b. KIND OF BUSINESS OR INDUSTRY Produce House

11. BIRTHPLACE (State or foreign country) Springfield, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Wallace

13b. MOTHER'S MAIDEN NAME Anna Forrester

14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown

16. SOCIAL SECURITY NO. unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ted Wright Springfield, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage massive
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) from Esophageal Varices ruptured
DUE TO (c) Cirrhosis of Liver.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 1 day

5810

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No

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) _____

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 22 Jan, 1950 to 23 Jan, 1950, that I last saw the deceased alive on 23 Jan, 1950, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Newton Wakeman M.D. Woodruff Rd. Springfield Mo

23b. ADDRESS _____

23c. DATE SIGNED 1-25-50

24. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan. 26, 1950

24c. NAME OF CEMETERY OR CREMATORY Greenlawn

24d. LOCATION (City, town, or county) (State) Springfield, Missouri

DATE REC'D BY LOCAL REG. 1-25-50

REGISTRAR'S SIGNATURE W.S. Handley M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loman-Bochardt - Springfield Mo

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

376

0396

0

6.

FEB 1 1950

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.

Signed _____

Signed _____
Student Embalmer

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.