

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

19543

State File No.

FILLED JUNE 28 1952

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 632

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 6 yrs.		d. STREET ADDRESS (If rural, give location) 2105 avannah Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Meth. Hospital			

3. NAME OF DECEASED (Type or Print) ROBERT			a. (First)	b. (Middle) F	c. (Last) WALLACE	4. DATE OF DEATH (Month) (Day) (Year) June 12 1952		
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5. SEX Male ()	6. COLOR OR RACE "hite"	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 2, 1863	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Grocer	10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME R. H. Wallace	13b. MOTHER'S MAIDEN NAME unk	14. NAME OF HUSBAND OR WIFE Mrs. Ella Wallace
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ella Wallace	ADDRESS St. Joseph Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subdiaphragmatic abscess.		DUE TO (b) _____		6 day
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 6-7, 1952, to 6-12, 1952 that I last saw the deceased alive on 6-12, 1952 and that death occurred at 7:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE H. W. Berke	(Degree or title) O. M. D.	23b. ADDRESS St. Joseph Mo.	23c. DATE SIGNED 6-13-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 13 1952	24c. NAME OF CEMETERY OR CREMATORY Kingman	24d. LOCATION (City, town, or county) (State) Kansas
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DATE REC'D BY LOCAL REG. June 19, 1952	REGISTRAR'S SIGNATURE Carl E. Castel	25. FUNERAL DIRECTOR'S SIGNATURE Stoney Funeral Home	ADDRESS St. Joseph Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph mo

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.