S. No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAR 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4629

BIRTH NO. _____ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 27

1. PLACE OF DEATH
a. COUNTY: Harrison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bethany
c. LENGTH OF STAY (in this place): 30 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Harrison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bethany
d. STREET ADDRESS (If rural, give location): 041 0

3. NAME OF DECEASED (Type or Print)
a. (First): FREDERICK
b. (Middle): -
c. (Last): WALLACE

4. DATE OF DEATH (Month) (Day) (Year): Feb. 24, 1954

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 24, 1884

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months | Days
IF UNDER 1 HR.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Building Painter

11. BIRTHPLACE (State or foreign country): Darlington, Mo. 0

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Elisha Wallace

13b. MOTHER'S MAIDEN NAME: Martha R. Burton

14. NAME OF ~~HUSBAND OR~~ WIFE: Laura Wallace

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

16. SOCIAL SECURITY NO.: 487-14-6813

17. INFORMANT'S SIGNATURE OR NAME: Sylvia Miles
ADDRESS: Bethany, 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): Senility
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): Creeping Palsy
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Anemia & Low Blood Pressure

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* 12-23, 1952, *to* 2-23, 1954, *that I last saw the deceased alive on* 2-23, 1954, *and that death occurred at* 10 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ernest R. Hood, D.O.
23b. ADDRESS: Bethany, Mo.
23c. DATE SIGNED: 2-25-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb. 27, 1954
24c. NAME OF CEMETERY OR ~~CREMATORY~~: Miriam Cemetery
24d. LOCATION (City, town, or county) (State): Bethany, Mo.

DATE REC'D BY LOCAL REG.: 2/26-54
REGISTRAR'S SIGNATURE: Zola Burris 116 0
25. FUNERAL DIRECTOR'S SIGNATURE: Clark L. Foster
ADDRESS: Bethany, Mo

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Clark L. Foster

Signed.....
Student Embalmer

Licensed Embalmer No. 4831

P. O. Address Bethany, Me

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.