

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26380

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 865

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. LENGTH OF STAY (in this place) Lifetime	c. CITY OR TOWN St. Joseph
d. FULL NAME OF HOSPITAL OR INSTITUTION 2119 St. Joseph Ave.		e. STREET ADDRESS (If rural, give location) 2119 St. Joseph Ave. 0117	

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) WALL c. (Last) WALL			4. DATE OF DEATH (Month) 8 (Day) 3 (Year) 1954		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-6-1900	9. AGE (in years last birthday) 53	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) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Forest City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME James Wall		13b. MOTHER'S MAIDEN NAME Clara Hare		14. NAME OF HUSBAND OR WIFE Myrtle Wall	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Nora Lytton, 2119 St. Joseph Ave., St. Joseph, Mo.		ADDRESS	
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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 Ukn.	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of larynx					
		ANTECEDENT CAUSES					
		Morbid 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 General Debility					
		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 5-28, 1954, to 8-3, 1954, that I last saw the deceased alive on 8-3, 1954, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE H. F. Mundy, M.D.		(Degree or title)		23b. ADDRESS 2801 Sacramento St. Joseph, Mo.		23c. DATE SIGNED 8-5-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-7-1954		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
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DATE REC'D BY LOCAL REG. Aug 10, 1954		REGISTRAR'S SIGNATURE Esther M. Allison		FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS St. Joseph, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 22 1952

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, ~~on~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *John E. Rupp*
Licensed Embalmer No. *390*
P. O. Address *H. Joe*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.