

FILED MAY 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 017738
STATE FILE NUMBER

Registration District No. 165 Primary Registration District No. 5602 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY Johnson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Johnson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chilhowee Twp		Inside Limits Yes ☐ No ☒	c. CITY OR TOWN Rural Centerview		Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes ☐ No ☐
3. NAME OF DECEASED (Type or print) First James Middle William Last Wallace			4. DATE OF DEATH Month May Day 15 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH Feb. 2, 1876		9. AGE (In years low birthday) 81
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 (City and state or country) Johnson County, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13a. FATHER'S NAME C.D. Wallace		13b. MOTHER'S MAIDEN NAME Margaret Bradley		14. NAME OF HUSBAND OR WIFE Sallie Knight Wallace	
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 Address Joe Wallace, Centerview, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Uremia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592x					INTERVAL BETWEEN ONSET AND DEATH 3 months 10 days
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE WORK AT WORK ☐		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 3-13-57 to 5-15-57 and last saw ^{her} alive on 5-8-57 Death occurred at 11 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE R W Jones (Degree or title) Do		22b. ADDRESS Holden, Mo		22c. DATE SIGNED 5-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/57		23c. NAME OF CEMETERY OR CREMATORY Providence	
23d. LOCATION (City, town, or county) Near Chilhowee, Mo.		(State)			
24. FUNERAL DIRECTOR Cook Funeral home, Chilhowee, Mo		25. DATE RECD. BY LOCAL REG. 5/18/57		26. REGISTRAR'S SIGNATURE J. Cook	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4335

P. O. Address. Chilhoway

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.