

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031152

FILED VS AUG 24 1959

Registration District No. 22

Primary Registration District No. 6087

Registrar's No. 5

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Slater</u>		Length of stay in 1b <u>18 Mo.</u>	c. CITY OR TOWN <u>Slater.</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>230 West Maple</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>230 W. Maple</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T.</u> Last <u>Wallace</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1872</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>David W. Wallace</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy E. Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Henderson Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harry Wallace</u> Address <u>Slater Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Slater, Mo.</u>	COUNTY <u>Saline</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 5-9-59 to 8-17-59 and last saw him alive on 8-16-59
Death occurred at 10:06 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. A. McBurney M.D.</u>	22b. ADDRESS <u>Slater, Mo.</u>	22c. DATE SIGNED <u>8/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-17-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>	23d. LOCATION (City, town, or county) <u>Carrollton, Mo.</u>
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24. FUNERAL DIRECTOR <u>Gibson Funeral Home</u>	ADDRESS <u>Carrollton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Raymond Brane</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.