

# DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031362

FILED VS OCT 2 1959

Registration District No. 002 Primary Registration District No. 5015 Registrar's No. 53

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>ANDREW</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ANDREW</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lincoln Township</b>			Length of stay in 1b	c. CITY OR TOWN <b>RFD # 1 Amazonia</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 mi. NE of Amazonia</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 mi. NE Amazonia</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARY ELIZABETH WALLACE</b>				First	Middle	Last	4. DATE OF DEATH <b>September 16, 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/63</b>	9. AGE (last birthday) <b>96</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Darlington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Elizah Webb</b>			13b. MOTHER'S MAIDEN NAME <b>Allie Mariah Fuller</b>			14. NAME OF HUSBAND OR WIFE <b>Dave Wallace</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT Address <b>Mrs. Harry Frazier, Amazonia, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> <b>meningitis left side</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis</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							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>several years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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		COUNTY		STATE	
21. I attended the deceased from <b>Sept 8-59</b> to <b>Sept 16-59</b> and last saw her alive on <b>Sept 16-1959</b> Death occurred at <b>6:30</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Ralph A. Kelley M.D.</b>				22b. ADDRESS <b>Savannah Mo</b>			22c. DATE SIGNED <b>9-17-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oregon Cemetery</b>		23d. LOCATION (City, town, or county) <b>Oregon, Missouri</b>		(State)		
24. FUNERAL DIRECTOR <b>Breit Funeral Home, Savannah</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-22-59</b>		26. REGISTRAR'S SIGNATURE <b>Lillian Sparks</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

001 8 1959

**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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.