

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-035322

STATE FILE NUMBER

FILED VS OCT 26 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1050

V. S. 300  
ev. 1-57

securing the medical certification in the specific manner required by VS. 120 MO. ST. 1959.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>St Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SAVANNAH</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Osteopathic</u>		Length of stay in lb <u>11 days</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Wallace</u> Last <u>Wallace</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Andrew Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Clarke</u>		13b. MOTHER'S MAIDEN NAME <u>Bell Tarrall</u>	
14. NAME OF HUSBAND OR WIFE <u>James C Wallace</u>		17. INFORMANT <u>Clayton Coatt 416 N 5th Savannah Mo</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>	
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>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) <u>Influenza, etc.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13 hours.</u> <u>Years</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		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 <u>March 15, 1947</u> to <u>Oct. 15, 1959</u> and last saw her alive on <u>Oct. 15, 1959</u> Death occurred at <u>4:05</u> a. m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>Maxwell, D.O.</u> 2 22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u> 22c. DATE SIGNED <u>10/16/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>10-16-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>		23d. LOCATION (City, town, or county) (State) <u>SAVANNAH MO</u>	
24. FUNERAL DIRECTOR <u>Breit Funeral Home SAVANNAH MO</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 19, 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

DEC 8 1958

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 *James B. Hawkins* .....

Licensed Embalmer No. *453-6* .....

P. O. Address *St. Louis* .....

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.