

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 8 1960

59-047118

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 412

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Marion			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b 3 wks		c. CITY OR TOWN Hannibal		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital			Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 215 a So 7th St		Reside on Farm Yes ☐ No ☒
3. NAME OF DECEASED (Type or print) First Middle Last John M. Wallace				4. DATE OF DEATH Month Day Year 11 - 28 - 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano tuner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Linn Ohio		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Helen 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.		17. INFORMANT Address Ralph Clark Hannibal, 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) Pulmonary embolism - DUE TO (b) Thrombosis of leg - DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown		
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	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. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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 11/1/59 to 11/29/59 and last saw her alive on 11/28/59 Death occurred at 10:00A on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Walter Hamilton M.D.			22b. ADDRESS Hannibal Mo.			22c. DATE SIGNED	
23a. BURIAL, CREATION, REMOVAL (Specify) Burial	23b. DATE 11-30-1959	23c. NAME OF CEMETERY OR CREMATORY Truxton Cemetery		23d. LOCATION (City, town, or county) Truxton, Mo.		(State)	
24. FUNERAL DIRECTOR ADDRESS Clark Funeral Home - Hannibal, Mo.			25. DATE RECD. BY LOCAL REG. 4/4/60		26. REGISTRAR'S SIGNATURE Dr. E.M. Lucke by Lillian M. Herman		

(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

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.