

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004704

FILED VS. FEB. 1 1960

324

Primary Registration District No. 6092

Registrar's No. 16

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) OR TOWN <u>Grand Pass T.W.P.</u>		Length of stay in 1b <u>8 mo</u>		c. CITY OR TOWN <u>Marshall</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>4 mi N. Malta Bend mo</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>305 E College</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY WALLACE</u>				4. DATE OF DEATH Month Day Year <u>January 28, 1960</u>				
5. SEX <u>male</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>June 17, 1871</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Cream Factory</u>		11. BIRTHPLACE (City and state or country) <u>Springfield Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>W. H. Wallace</u>			13b. MOTHER'S MAIDEN NAME <u>Noamie Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Estelle Ego 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>494-12-0490</u>		17. INFORMANT Address <u>Mrs O.H. Mahmeyer Malta Bend 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>chronic arteriosclerosis generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs plus</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		
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		COUNTY STATE		
21. I attended the deceased from <u>about 1950</u> to <u>Jan 27, 1960</u> and last saw xxx him alive on <u>Jan 27, 1960</u>				Death occurred at <u>9:45 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>George A. Kelling MD</u>				22b. ADDRESS <u>Waverly, Missouri</u>		22c. DATE SIGNED <u>1/30/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-30-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Grand Pass mo</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Harry Heraburger Marshall mo</u>			25. DATE RECD. BY LOCAL REG. <u>1-29-'60</u>		26. REGISTRAR'S SIGNATURE <u>Cecil G. Reel</u>			

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 7

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