

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-012096**

FILED VS MAR 23 1960

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 44 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u>		c. CITY OR TOWN <u>LOUISIANA</u>	
Length of stay in 1b <u>LIFE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>PIKE CO HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>316 N 16th St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>GROVER CLEVELAND WALLACE</u>			4. DATE OF DEATH Month Day Year <u>MAR 15 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</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>12-25-1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>NURSEY MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT NURSERY</u>		11. BIRTHPLACE (City and state or country) <u>LOUISIANA MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>IONE NEWMAN</u>	
14. NAME OF HUSBAND OR WIFE <u>MYRTLE J 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>500-05-0989</u>	
17. INFORMANT <u>Mrs MYRTLE J WALLACE</u>		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>C. V. A. (Recurrent)</u>		<u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic hypertensive cardio vascular disease</u>	<u>10 yrs</u>
	<u>Pyleonephritis</u>	
	DUE TO (c) <u>gastro-intestinal hemorrhage</u>	<u>6 weeks</u>

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 e.m. p.m.	Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1953 to 3/15/60 and last saw him alive on 3/15/60  
Death occurred at 6:15 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Chas H Lewellen M.D.</u>	22b. ADDRESS <u>122 South 3rd Louisians, Mo.</u>	22c. DATE SIGNED <u>3/17/60</u>
23a. BURIAL CREMATION, RECEPTION (Specify) <u>BURIAL</u>	23b. DATE <u>3-18-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM</u>
23d. LOCATION (City, town, or county) (State) <u>LOUISIANA MO</u>		
24. FUNERAL DIRECTOR <u>COLLETT FUNERAL SERVICE</u>	25. DATE RECD. BY LOCAL REG. <u>3-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
ADDRESS <u>LOUISIANA MO</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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.