

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-61-012754**

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 430

STATE FILE NUMBER

**FILED MAY 1 1961**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in 1b <b>9 years.</b>	c. CITY OR TOWN <b>St. Joseph</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3108 Jules St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3108 Jules Street</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Wallace</b>			4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1961.</b>			
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5. SEX <b>Male</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>Sept. 27, 1874 86</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Robert Wallace</b>	13b. MOTHER'S MAIDEN NAME <b>Sally Jane Prickett</b>	14. NAME OF HUSBAND OR WIFE <b>Carrie Wallace</b>
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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>none</b>	17. INFORMANT <b>Mrs. Edra Leava</b> Address <b>St. Joseph, Mo.</b>
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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 Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>(about 19 days)</b>
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) <b>Myocardial Insufficiency</b>		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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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
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21. I attended the deceased from 4/4/61 to 4/24/61 and last saw <sup>her</sup>him alive on 4/23/61  
Death occurred at 6:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Jay Redmond M.D.</b>	22b. ADDRESS <b>St Joseph, Mo</b>	22c. DATE SIGNED <b>4/25/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Apr. 26, 1961.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graves Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Gulford, Missouri.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>April 27, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **W. H. Redmond, M.D.** MEDICAL CERTIFICATION

**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 *Robert P. Harrington*

Licensed Embalmer No. 3258

P. O. Address A Joseph

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.