

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020191

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 87

FILED MAY 23 1961

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Cedar</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Length of stay in lb <b>1 yr</b>	c. CITY OR TOWN <b>Eldorado Spg. R2</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>#820 West Hunter St. Manlove N. Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10 Mills. Pouch</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MARTHA-JANE-WALLACE</b>			4. DATE OF DEATH Month Day Year <b>May 18 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1875</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (City and state or country) <b>Jerico Spg. Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>		
13a. FATHER'S NAME <b>W. R. Hall</b>		13b. MOTHER'S MAIDEN NAME <b>Nannie Beckley</b>		14. NAME OF HUSBAND OR WIFE <b>R. J. Wallace</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Clyde Wallace, <del>Jerico Spg. Mo</del></b> Address <b>Eldorado</b>		

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) <b>Cardiac arrest</b>	<b>5 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <b>Arteriosclerotic heart disease</b>	<b>1 year</b>	
DUE TO (c) <b>Generalized arteriosclerosis</b>	<b>3 year</b>	
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 checked="" 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 <b>5/18/60</b> to <b>5/18/61</b> and last saw her <b>live</b> on <b>5/15/61</b> . Death occurred at <b>7:00</b> a m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>Ray W. Jones MD</b>	22b. ADDRESS <b>Nevada Mo</b>	22c. DATE SIGNED <b>5/18/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>5-20-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hall Cem.</b>
		23d. LOCATION (City, town, or county) <b>47. Jerico Spg. Mo</b>

24. FUNERAL DIRECTOR <b>Long F. H.</b> ADDRESS <b>Jerico Spring, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 20-1961</b>	26. REGISTRAR'S SIGNATURE <b>Anna E. Jerry</b>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
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 Dr. D. Long

Licensed Embalmer No. 371X

P. O. Address Jerico St.

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.