

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002683

STATE FILE NUMBER

AMENDED

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 3
FILED JAN 23 1962

1. PLACE OF DEATH a. COUNTY <u>MARIES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MARIES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BELLE</u>		c. CITY OR TOWN <u>BELLE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS (If outside, give location) <u>_____</u>	
3. NAME OF DECEASED (Type or print) <u>AUGUSTA FRANCIS WALLACE</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH <u>10/25/76</u>
9. AGE (last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 24 HR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANDREW BACKUES</u>		13b. MOTHER'S MAIDEN NAME <u>HANNA M. KEENEY</u>	
14. NAME OF HUSBAND OR WIFE <u>EDWARD A. WALLACE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WILBUR WALLACE, BELLE 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>CARDIAC ARREST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIAC ANOXIA</u>		<u>1 yr -</u>	
DUE TO (c) <u>COR. PULMONARY</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <u>FRacture of Femur</u>		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.	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 <u>12-8-16-61</u> to <u>1-16-62</u> and last saw her alive on <u>1-16-62</u> Death occurred at <u>3:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. F. L. L. L. L.</u>		22b. ADDRESS <u>Bland, Mo</u>	
22c. DATE SIGNED <u>1-19-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1/18/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LIBERTY CEMETERY NEAR BELLE MO</u>	23d. LOCATION (City, town, or county) (State) <u>MO</u>
24. FUNERAL DIRECTOR <u>HOWARD JONES BELLE MO</u>		25. DATE RECD. BY LOCAL REG. <u>1-20-62</u>	
26. REGISTRAR'S SIGNATURE <u>Wm. F. L. L. L. L.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Omer Howard Jones

Licensed Embalmer No. *4411*

P. O. Address

Belleme

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.