

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033347

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 179

FILED SEP 10 1962	
1. PLACE OF DEATH	
a. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Marshall</u> Length of stay in lb OR <u>Life</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Fitzgibbon Hospital</u> Inside Limits INSTITUTION Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
c. CITY OR TOWN <u>Marshall</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>728 W Odell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	
First <u>WILLIAM</u>	Middle <u>EARP</u>
Last <u>WALLACE</u>	
4. DATE OF DEATH	
Month <u>8</u>	Day <u>30</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>4-4-1898</u>
9. AGE (last birthday) <u>64</u>	
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) <u>Stone cutter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Monument Co.</u>	
11. BIRTHPLACE (City and state or country) <u>GrandPass, Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm. Henry Wallace</u>	
13b. MOTHER'S MAIDEN NAME <u>Estelle Earp</u>	
14. NAME OF HUSBAND OR WIFE <u>Lorine 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>X</u>	
17. INFORMANT <u>Mrs. Thomas W. Ballew</u> Address <u>Marshall, 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>Myocardial Infarction</u>	
DUE TO (b) <u>Coronary Occlusion</u>	
DUE TO (c) <u>Arteriosclerotic Vas Disease</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	
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>1958</u> to <u>8-30-62</u> and last saw her alive on <u>8-30-62</u> . Death occurred at <u>4:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>[Signature]</u>	
22b. ADDRESS <u>Marshall, Missouri</u>	
22c. DATE SIGNED <u>9-1-1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>9-3-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RIDGE PARK CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>MARSHALL</u> (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Jack W Reser</u> ADDRESS <u>Marshall, Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>9-3-1962</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

NOV 23 1962

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 Bill McLaughlin

Licensed Embalmer No. 5160

P. O. Address Marshall, Mo.

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.