

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004885

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 3

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JAN 21 1963

1. PLACE OF DEATH a. COUNTY Taney		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Branson		Length of stay in 1b 5 days	c. CITY OR TOWN Reeds Spring Inside Limits Yes ☐ No ☒
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Skaggs Hosp.		Inside Limits Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) Highway 65 Reside on Farm Yes ☐ No ☒
3. NAME OF DECEASED (Type or print) JOHN DYE WALLACE		4. DATE OF DEATH Month Jan. Day 5 Year 1963	
5. SEX M	6. COLOR OR RACE W	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 8/29/1896
9. AGE (last birthday) 66		IF UNDER 1 YEAR Months 4 Days 6 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Store Manager	11. BIRTHPLACE (City and state or country) Charleston, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John Marion Wallace	
13b. MOTHER'S MAIDEN NAME Dora Bell Scott		14. NAME OF HUSBAND OR WIFE Grace Wallace	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Grace Wallace Reeds Spring, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) 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. Month, Day, Year _____		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 Branson Mo.	
20g. COUNTY Stone		20h. STATE Missouri	
21. I attended the deceased from 1/1/60 to 1/5/63 and last saw him alive on 1/5/63 Death occurred at 1:40 A M on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Roy Lillie M.D.		22b. ADDRESS Branson Mo.	
22c. DATE SIGNED 1/10/63		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1/7/1963	
23c. NAME OF CEMETERY OR CREMATORY Rome Center Cemetery		23d. LOCATION (City, town, or county) Orwell, Ohio	
24. FUNERAL DIRECTOR Walter Cobb		25. DATE RECD BY LOCAL REG. 1/14/63	
26. REGISTRAR'S SIGNATURE John Campbell			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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JAN 22 1963

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 _____

Walter Cook

Licensed Embalmer No. 40731

P. O. Address Bloomington, 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.