

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027746

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 87 Primary Registration District No. 4565 Registrar's No. 62

FILED JUL 16 1963

VS 300
Rev. 4/59

1 0.281

2 0.31-0

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4 0

5 2

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12 1-0

13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Crawford</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sullivan</u> | | c. CITY OR TOWN <u>Union</u> | |
| Length of stay in 1b <u>10 dys</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sullivan Community</u> | | d. STREET ADDRESS (If outside, give location) <u>Rt. 2</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl W Wallace</u> | | 4. DATE OF DEATH Month Day Year <u>July 7, 1963</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/15/92</u> |
| 9. AGE (last birthday) <u>70</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 11. BIRTHPLACE (City and state or country) <u>Moselle, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>John W. Wallace</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Mary Longacre</u> | | 14. NAME OF HUSBAND OR WIFE <u>Hilda (Deceased)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Eugene Wallace, Union, Mo.</u> | | 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) <u>Myocarditis; Advanced Arteriosclerosis;</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pleural Effusion; Pulmonary Edema and Congestion</u> DUE TO (c) <u>Arteriosclerotic heart disease, uncompensated</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</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>Apr 1963</u> to <u>July 7, 1963</u> and last saw her/him alive on <u>July 6, 1963</u> Death occurred at <u>Sullivan Community Hosp. P.P.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Royce M. H.</u> | | 22b. ADDRESS <u>316 Elm St. Sullivan Mo</u> | 22c. DATE SIGNED <u>7/10/63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7/10/63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>I O O F Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Clair, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Casey-Lenox F.H.</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 11, 1963</u> | 26. REGISTRAR'S SIGNATURE <u>William Cowan</u> |

USE BLACK INK OR TYPEWRITER RIBBON

JUL 18 1968

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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 *H. M. Lewis*

Licensed Embalmer No. 3601

P. O. Address: St. Charles, 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.