LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr Davis

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Shelby

Township Clay

or

Village Clarence

or

City ..... (NO. ..... St.; ..... Ward)

Registration District No. 827 File No. 19209

Primary Registration District No. 4500 Registered No. 55

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mason Melvin Wallace

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Sep 27, 1843 (Month) (Day) (Year)

7 AGE 74 yrs. 8 mos. ~~5~~ ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (City or town, State or foreign country) New Hampshire

PARENTS

10 NAME OF FATHER Rubin Wallace

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) New Hampshire

12 MAIDEN NAME OF MOTHER Annie Howard

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adelia Davis

(Address) Clarence Mo

15 Filed May 31, 1918 W. M. Baylies Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month), 27 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 20, 1918, to May 27, 1918, that I last saw him alive on May 25, 1918, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

(Duration) 2 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Davis M. D.

May 27, 1918 (Address) Clarence Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Clarence

DATE OF BURIAL 5-29, 1918

20 UNDERTAKER E E Hopper

ADDRESS Clarence

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE .....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.