

OCT 18 1934

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

Do not use this space.

35074

1. PLACE OF DEATH

County *North*Registration District No. *903 965*

File No.

Township *Bellevue*Primary Registration District No. *1 216*

Registered No.

City *St. Louis*

St. Ward)

2. FULL NAME

(a) Residence, No. *1015 1/2* St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *75* yrs. *8* mos. *13* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (or the one word)5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Jessiah Wallace*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *75* *8* *13*8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Retired*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Farmer*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Snout City, Mo*
*North Co*13. NAME *Amberland Wallace*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*15. MAIDEN NAME *Jessiah Jobe*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Pennsylvania*17. INFORMANT (ADDRESS) *Cleo Wallace*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Deadora, Mo* DATE *9-17* 19*34*19. UNDERTAKER (ADDRESS) *Andrew*
*Snout City, Mo*20. FILED *Oct 9, 1934* *Fred Mull, Md* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 15* 19*34*22. I HEREBY CERTIFY, That I attended deceased from *Sept 4* 19*34* to *Sept 7* 19*34*I last saw him alive on *Sept 7* 19*34* Death is saidto have occurred on the date stated above, at *12:30* p.m.

The principal cause of death and related causes of importance were as follows:

*Anterior poliomyelitis and**sepsis of liver*Other contributory causes of importance *46*Name of operation *None* Date of *None*What test confirmed diagnosis? *None* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *No* Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify *Yes*(Signed) *Geo M. Neale*, M. D.(Address) *Snout City, Mo*

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County North
Township Allen
City Bolivar (No. _____)

Registration District No. 965
Primary Registration District No. 6216

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Bolivar Wall
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 24 - 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 - 8 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 _____

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept - 15 - 1934

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19_____

I last saw h..... alive on _____, 19_____ Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance: 46

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19_____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

Jas. M. Reed
Registrar

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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