

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

MAY 18 1939

14135
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 912
 (b) Township Curran Primary Registration District No. 6237A Registered No. 14
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 10 yrs. - mos. - ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME NANCY JANE WALLACE

(a) Residence, No. Andrew Co St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James M. Wallace
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-27-1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 3 22
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/19/39 1939
 22. I HEREBY CERTIFY, That I attended deceased from Apr 17, 1939, to Apr 19, 1939
 I last saw h.s. & alive on Apr 19, 1939. Death is said to have occurred on the date stated above, at 8:30pm.
 The principal cause of death and related causes of importance were as follows:
Acute Endocarditis
 Date of onset _____
 Other contributory causes of importance:
Scurvy
Coronary hemorrhage
 Name of operation no Date of _____
 What test confirmed diagnosis? autopsy Was there an autopsy? no
 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? no
 If so, specify _____
 (Signed) D. R. Marshall M.D.
 (Address) Vandalia Mo. D.O.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia
 13. NAME Dorsey Baker
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia
 15. MAIDEN NAME Elizabeth Wright
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia
 17. INFORMANT Bessie M. Kinsey
 (ADDRESS) Middletown, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Middletown Mo DATE April-21-1939
 19. FUNERAL DIRECTOR (NAME) Pitchett - Kubne
 (ADDRESS) Middletown Mo.
 20. FILED Apr 20, 1939 Carrie F. Utterback Local Registrar.

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.

RECEIVED

District Health Officer No. 10

District No. 10-39-771

Date Filed MAY 8 1939

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Clifford C. Kuhner*

Licensed Embalmer No. *3059*

P. O. Address *Wellsville 7*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.