

WRITE IN INK—USE INK—MAKE A FEMALE 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.

Registration District No. 134

Primary Registration District No. 5189

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Combs twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days 11 7 40

3. (a) PRINT FULL NAME Orelenta A Wallace
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife J. J. Wallace 6. (c) Age of husband or wife alive years _____
7. Birth date of deceased 5 (Month) 28 (Day) 1924 (Year)

8. AGE: Years 95 Months 8 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Carroll Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Unp
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Nettie Jenkins
(b) Address Carrollton Mo

17. (a) Buried (b) Date thereof Jan-30-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Willis Chapel Car

18. (a) Signature of funeral director Stanley
(b) Address Carrollton Mo

19. (a) Jan-30 (b) Mrs. A. G. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Combs twp (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28 year 1940 hour 7 minute 20A.M.

21. I hereby certify that I attended the deceased from 1-27-40, 19____, to 1-28, 19____, and that death occurred on the date and hour stated above.

that I last saw he alive on 1-27-40, 19____; Immediate cause of death Ch. Cardiovascular Disease

Due to _____
Due to A. J. W
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature H. B. Deven (M. D. or other) MD
Address Carrollton Mo Date signed 1-28-40

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 1/9/40

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 Ben W. Gibson
Licensed Embalmer No. 2961
P. O. Address Carrollton, W.

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