

3. No. 2
-4-13-40
5-17-39
P-1 X23159

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County St. Joseph
(b) City or town St. Joseph
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days) 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Richman
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 223 California Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Fred D. Wallace

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife Mae 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 29 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Paris Mich
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Painter

11. Industry or business _____

12. Name Frank Wallace

13. Birthplace Paris Mich
(City, town, or county) (State or foreign country)

14. Maiden name Electa Lancaster

15. Birthplace Sum Dale Mich
(City, town, or county) (State or foreign country)

16. (a) Informant Virgil Wallace

(b) Address 28 1/2 to 20 W

17. (a) Burial (b) Date thereof 2-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Wm J. Garry
(b) Address 18 to 10 St. Joseph Mo

19. (a) Feb 11 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
year 1941 hour 7 minute 00 P M.

21. I hereby certify that I attended the deceased from 1-12, 1941, to 2-1, 1941;
that I last saw him alive on 2-1, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure (Myoperitomy)

Due to Chronic pulmonary congestion &

Other conditions X
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy yes see above

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? X (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? NE
(Specify type of place) (e) Means of injury: _____

23. Signature Dr. W. D. Tracy (M. D. or other) D.M.O.
Address St. Joseph Mo Date signed 2-3-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No. *3220*

P. O. Address *St. Joseph, 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 this body is not embalmed, fact should be so stated above.