No. 2
4-13-40
17-39
23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 25 1942

Registration District No. 2-8

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5405

State File No. 6528

Registrar's No. 39

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

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Arbyrd R. #1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Clay Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Dunklin
(c) City or town: Arbyrd Mo R 1-D
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: DORLIS LEVON WALLACE

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, divorced: (1)

6. (b) Name of husband or wife: ✓

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: March (Month) 1 (Day) 1937 (Year)

8. AGE: 4 Years, 11 Months, 1 Days; If less than one day ..... hr. ..... min.

9. Birthplace: Opelaka Alabama (City, town, or county) (State or foreign country)

10. Usual occupation: Child

11. Industry or business: ✓

FATHER
12. Name: A. L. Wallace
13. Birthplace: Kennerly Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Ora Nell Jones
15. Birthplace: Caruthersville Mo (City, town, or county) (State or foreign country)

16. (a) Informant: A. L. Wallace
(b) Address: Arbyrd Mo

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 3/1/42 (Date received local registrar) (b) Lyndon B. Pullins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6th year 1942 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from 2-5-42, 19..., to 2-6-42, 1942 that I last saw her alive on 2-5-42, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal Obstruction — Duration 2-5-42

Due to .....

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

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

23. Signature: C. E. Robinson (M. D. or other) 0
Address: Leachville Date signed 2-11-42

1201

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 342-366
Date Filed 3/12/42

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.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6528

Registration District No. 287 Primary Registration District No. 5405 Registrar's No.

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Rural
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Donlis Wallace
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Mar (Month) 1 (Day) 1937 (Year)
8. AGE: Years 4 Months 11 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
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
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) Lynden B Perkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 28 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Probable Appendicitis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 12 hr	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Dr A L Robinson (M. D. or other) MD
Address Poplarville Ark. Date signed

SUPPLEMENTARY