. S. No. 2
DM—8-43
v. 5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1945

State File No. 42594

Registration District No. 325 Primary Registration District No. 4479 Registrar's No. 12

1. PLACE OF DEATH:
(a) County Schuyler
(b) City or town Queen City Mo
(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 MO (b) County Schuyler
(c) City or town Queencity MO 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dr W. H. Wallace
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced / X
6. (b) Name of husband or wife Nannie E. Wallace
6. (c) Age of husband or wife if alive 91 years
7. Birth date of deceased Feb. (Month) 17 (Day) 1859 (Year)

8. AGE: Years	Months	Days	If less than one day
86	9		hr. min.

9. Birthplace unknown (City, town, or county) Wyatt Ill. (State or foreign country) /
10. Usual occupation Doctor
11. Industry or business /
FATHER 12. Name Coleman Wallace
13. Birthplace unknown (City, town, or county) (State or foreign country) ?
MOTHER 14. Maiden name unknown
15. Birthplace " " (City, town, or county) (State or foreign country) ?
16. (a) Informant John Bizzo.
(b) Address Queen City, Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof 11-17-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Queen City Cemetery
18. (a) Signature of funeral director Wm H West
(b) Address Queencity Mo
19. (a) 11/17-1945 (Date received local registrar) (b) R. J. Drake (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov., 17th 1945
year 1945 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from Oct., 2nd, 1945 to Nov., 16, 1945
that I last saw him alive on Nov. 15th, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Apoplexy, resulting in paralysis of lefy side of body. — 3 Mont
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature J. D. Coffey (M. D. or other)
Address Queen City, Mo. Date signed 11/17-1945

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

1493

(Licensed Embalmer's Statement on Reverse Side)

JAN 25 1946

RECEIVED
District Health Officer No. 10
District File Number 12-45-1886
Date Filed DEC 20 1945

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 Wm A Hedt

Licensed Embalmer No. 2882

P. O. Address Queencity 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.