

No. 2
M-5-43
5-17-39
I X36671

U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FILED SEP 3 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26382

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 969

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 1/2 days
(Specify whether years, months or days)
 In this community 62 years.

3. (a) PRINT FULL NAME Charles H. Wallace
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sara W. Wallace
 6. (c) Age of husband or wife if alive 78 years
 7. Birth date of deceased June 24 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>2</u>	<u>3</u>	hr. min.

9. Birthplace Jackson County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business Medicine

12. Name Joseph Wm. Wallace

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Jessamine Young

15. Birthplace Jessamine Co. Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. H. Wallace
 (b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 8/29/46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Heaton R. Gale & Proulx
 (b) Address St. Joseph, Mo.

19. (a) Aug. 31, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 605 No. 8th St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27
 year 1946 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from 8.25.46 to 8.27.46
 that I last saw him alive on 8.27.46
 and that death occurred on the date and hour stated above.

Immediate cause of death Essential pneumonia Duration 12 hr.
with myocardial degeneration 48 hrs.
 Due to

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

Major findings: —
 Of operations —
 Of autopsy — 93 D.

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

23. Signature [Signature] (M. D. or other) MD.
 Address St. Joseph, Mo. Date signed 8.27.46

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

25228

34

(Licensed Embalmer's Statement on Reverse Side)

NOV 21 1947

DEC 10 1948

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 *Raymond H. Overhead*

Licensed Embalmer No. *4413*

P. O. Address *319 So 10th 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.