

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **174**

Primary Registration District No. **3035**

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

1. PLACE OF DEATH:
 (a) County **Lafayette**
 (b) City or town **Livingston**
 (c) Name of hospital or institution: **823 South St 1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **40 yrs**
 In this community **40 yrs**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Lafayette**
 (c) City or town **Livingston**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **823 South St**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **JESSIE EDNA 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 **married**
6. (b) Name of husband or wife **Oscai E. Wallace** **6. (c) Age of husband or wife if alive** **57** years
7. Birth date of deceased **not known**
 (Month) (Day) (Year)

8. AGE: Years **abt 63** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **MO**
 (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER

12. Name **not known**
13. Birthplace _____
14. Maiden name **not known**
15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant **Oscai E. Wallace**

(b) Address **Livingston, MO**

17. (a) Burial **(b) Date thereof** **7-18-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mayview, MO**

18. (a) Signature of funeral director **Robert J. Dimpfel**

(b) Address **Livingston, MO**

19. (a) Aug 12, 1947 **(b) M. E. Lathrop**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **16**
 year **1947** hour **11** minute **35 P.M.**
21. I hereby certify that I attended the deceased from **July 12**
1, 19**47** to **July 16**, 19**47**
 that I last saw her alive on **July 16**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **Duration** _____

Due to **Hypertension**

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)** _____ **(r) Means of injury** **1**

23. Signature **Ben G. Gresham** (M. D. or other)

Address **Livingston, MO** **Date signed** **7/21/47**

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-22-47

Blair

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 *J. W. McKean*
Licensed Embalmer No. 2983

P. O. Address *Lurigen 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.