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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED JUL 29 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 23267  
Registrar's No. 133

Registration District No. 150

Primary Registration District No. 5572

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Praise Imp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson County Home for Aged  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 yrs. 5 mos. 14 d.  
(Specify whether  
In this community 30 yrs  
years, months or days)

3. (a) PRINT FULL NAME ROBERT WALLACE

3. (b) If veteran name war Unknown 3. (c) Social Security No. Unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced -P-9

6. (b) Name of husband or wife -P- 6. (c) Age of husband or wife if alive -P- years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 75 Months ✓ Days ✓ If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name

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

16. (a) Informant Jackson Co. Home, Records

(b) Address Rt. #4 - Indip. Mo.

17. (a) Anatomical (b) Date thereof July 12-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation F.C. College of Det. Surg.

18. (a) Signature of funeral director N.B. Gangesfort

(b) Address Lee's Swiss

19. (a) 7-12-48 (b) Donald C. Barnshaw  
(Date received local registrar) (Registrar's signature) 2/10

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City, Mo. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 510 Woodland  
(If rural, give location) 1  
(e) Citizen of foreign country? — (Yes or No)  
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 9, year 1948 hour 1 minute 4 M.

21. I hereby certify that I attended the deceased from Jan 24, 1947 to July 9, 1948  
that I last saw h. alive on July 8, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 9 B. 19

Of autopsy

Duration  
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 0

23. Signature J.P. Greene (M. D. or other)

Address Independence Mo Date signed 7/19/48

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**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 W B Langford  
Licensed Embalmer No. 5133  
P. O. Address Leis Summit D

**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.**

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