

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26196**

FILED AUG 22 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 873

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> c. LENGTH OF STAY (In this place) <u>7 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Worth</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hos.</u>		d. STREET ADDRESS (If rural, give location) <u>/</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Cora</u> b. (Middle) <u>Dell</u> c. (Last) <u>Wallace</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 11, 1949</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 24, 1876</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Days <u>1</u>	IF UNDER 12 HRS. Hours <u>17</u>	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Shelby, Indiana /</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Nathaniel Owens</u>	13b. MOTHER'S MAIDEN NAME <u>Dorothy Hendrickson</u>	14. NAME OF HUSBAND OR WIFE <u>Adam H. Wallace</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Salena Wallace</u> ADDRESS <u>St. Joseph</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Edema</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardia Decompensation</u> DUE TO (c) <u>Hypertension, Hs and Disease of Arterio Sclerosis Heart Disease</u>		3 weeks. ?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>			4 1/2 3X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug - 9, 1949, to Aug - 11, 1949, that I last saw the deceased alive on Aug - 10, 1949, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>T. L. Horden M.D.</u> (Degree or title)	23b. ADDRESS <u>St. Joseph, Mo 620</u>	23c. DATE SIGNED <u>8-11-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8/12/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Grant City</u>	24d. LOCATION (City, town, or county) (State) <u>Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Aug. 15, 1949</u>	REGISTRAR'S SIGNATURE <u>E. B. Jenkins</u> 382	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Newman</u> ADDRESS <u>319 E. 10th St. St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side) None

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

*E. Martin*

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *319 1010th St. Joplin*

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.