

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36950**

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>1017</u>				
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MORGAN</u> <u>999</u>						
b. CITY OR TOWN <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>11</u> days		c. CITY OR TOWN <u>JACKSONVILLE</u>						
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>VETERANS ADMINISTRATION HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>533 BROADWAY ALLEY</u>						
3. NAME OF DECEASED a. (First) <u>ELIJAH</u>			b. (Middle) <u>(NMI)</u>		c. (Last) <u>WALLACE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 21, 1949</u>			
5. SEX <u>MALE</u> <u>2</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>DECEMBER 19, 1893</u>		9. AGE (In years last birthday) <u>55</u>	10. MONTHS <u></u>	11. DAYS <u></u>	12. HOURS <u></u>	13. MIN. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>CLARKSVILLE, MISSOURI</u> <u>0</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>			16. SOCIAL SECURITY NO. <u>328 16 8083</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA RECORDS</u>			ADDRESS <u>VA HOSPITAL, SPRINGFIELD, MISSOURI</u>		
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, ashenia, etc. It means the disease, injury, or complication which caused death.										
MEDICAL CERTIFICATION										
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis, Far Advanced, Bilateral, Terminal Hemorrhage.</u>										
INTERVAL BETWEEN ONSET AND DEATH										
ANTECEDENT CAUSES										
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.										
DUE TO (b) _____										
DUE TO (c) _____										
II. OTHER SIGNIFICANT CONDITIONS <u>Bronchial Pneumonia, Bilateral, Terminal.</u>										
Conditions contributing to the death but not related to the disease or condition causing death.										
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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)					
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?					
22. I hereby certify that I attended the deceased from <u>NOV. 10</u> , 19 <u>49</u> , to <u>Nov. 21</u> , 19 <u>49</u> , XXXXXXXXXXXXXXXXXXXX that death occurred at <u>10:55 AM</u> from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <u>P.L. EISELE, M.D. CLINICAL DIRECTOR</u>				23b. ADDRESS <u>VA HOSPITAL SPRINGFIELD, MISSOURI</u>				23c. DATE SIGNED <u>11-21-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>11-22-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Jacksonville</u>			24d. LOCATION (City, town, or county) (State) <u>Jacksonville, Ill.</u>			
DATE REC'D BY LOCAL REG. <u>11-22-49</u>		REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u>			FUNERAL DIRECTOR'S SIGNATURE <u>Norman Schaefer</u>			ADDRESS <u>Springfield, Ill.</u>		

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

39
2
6

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.

Signed

L. Decker Gorman

Signed.....
Student Embalmer

Licensed Embalmer No. *3177*

P. O. Address *Springfield, Md*

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.