

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON

b. CITY (If outside corporate limits, write RURAL and give township)
KANSAS CITY

c. CITY OR TOWN KANSAS CITY

c. LENGTH OF STAY (in this place) 50 yrs.

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL

STREET ADDRESS (If rural, give location) 3675 SUMMIT ST.

3. NAME OF DECEASED (Type or Print)
a. (First) RUTH b. (Middle) ESTHER c. (Last) WALLACE

4. DATE OF DEATH (Month) (Day) (Year)
JAN. 20, 1955

5. SEX female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH December 6-1894 9. AGE (In years last birthday) 60

IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 1 HR. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ernest Eich 13b. MOTHER'S MAIDEN NAME Henrietta Oftendorf 14. NAME OF HUSBAND OR WIFE Truman J. Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Truman J. Wallace, Jr.--son K.C. Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Encephalomalacia

ANTECEDENT CAUSES (b) Cardiac Hypertrophy + Dilation

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c) Old myocardial infarct

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 4343

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES 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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that Patricia Hill died on Jan 20, 1955, at 19 m., from the causes and on the date stated above.

23a. SIGNATURE Jack H. Hill (Degree or title) _____ 23b. ADDRESS 500 W. Lyndale St. Kansas City, Mo. 23c. DATE SIGNED 20 Jan 55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Jan. 22-1955 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery 24d. LOCATION (City, town, or county) (State) Kansas City, Kansas

DATE REC'D BY LOCAL REG. 1-21-55 REGISTRAR'S SIGNATURE Neva Marshall 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Quirk & Tobin-20 W. Linwood, K.C., Mo.

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

wa 8351

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.....
Signature of Student Embalmer

Signed: *Forrest D. Goldsnow*.....

Licensed Embalmer No. *4714*.....

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.