

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035575

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 207 Primary Registration District No. \_\_\_\_\_ Registrar's No. 240

**FILED OCT 15 1962**

VS 300  
Rev. 4/59

10745  
20740

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>NODAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>NODAWAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LINCOLN TWSP.</b>		Length of stay in 1b <b>8 YRS. 6 MO.</b>	c. CITY OR TOWN <b>NEAR ELMO</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 MI. W. ELMO</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 MI. W. OF TOWN</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUTH DELORES WALLACE</b>			4. DATE OF DEATH Month Day Year <b>SEPT. 21, 1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/11/1912</b>
9. AGE (last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>DUNLAP, IOWA</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>THOMAS SURBER</b>	13b. MOTHER'S MAIDEN NAME <b>MYRTLE DEARDUFF</b>
14. NAME OF HUSBAND OR WIFE <b>DANIEL C. WALLACE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NOT KNOWN</b>
17. INFORMANT <b>D.C. Wallace</b>		Address <b>ELMO, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary; failure, due to carcinomatosis of the brainor possible liver toxemia due to cancer.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>
DUE TO (b) _____			
DUE TO (c) <b>Scirrhus carcinoma of breast, metastasis.</b>			<b>about 1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>April 13, 1962</b> to <b>Sep. 21, 1962</b> and last saw her alive on <b>Sep. 21, 1962</b>			
Death occurred at <b>9:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Harold Ford</i> (Degree or title) <b>D.O.</b>		22b. ADDRESS <b>ELMO, MISSOURI</b>	22c. DATE SIGNED <b>9/24/62</b>
23a. DESIRE FOR CREMATION, REMOVAL (Specify) <b>REM. &amp; BUR.</b>	23b. DATE <b>9/24/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CLARINDA CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CLARINDA, IOWA</b>
24. FUNERAL DIRECTOR <b>Boyd G. Nvinger Bedford</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>10-18-62</b>	26. REGISTRAR'S SIGNATURE <b>Beas Bolt</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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,

by Boyd G. Nowinger, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Boyd G. Nowinger

Licensed Embalmer No. 5136

P. O. Address Bedford, Iowa

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.