

FILED APR 25 1945

Registration District No. 276

Primary Registration District No. 3060

Registrar's No. 379

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Farmington
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James Augustus Wallace sr

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

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

6. (b) Name of husband or wife Lillian A. Wallace 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 1 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>8</u>	<u>7</u>	hr. _____ min.

9. Birthplace St. Francois County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business _____

12. Name Elias Wallace

13. Birthplace Green County Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Porter

15. Birthplace Rockbridge County Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. A. Wallace

(b) Address Farmington, Mo.

17. (a) b (b) Date thereof 4-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkview

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Mo.

19. (a) 4-13-45 (b) James Perkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th
year 1945 hour 4 minute _____

21. I hereby certify that I attended the deceased from April 8th 1945, to April 8th 1945, that I last saw him alive on April 8 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 1 hour

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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 _____

23. Signature L. M. Sharpe (M. D. or other) _____

Address Farmington, Mo. Date signed 4/14/45

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

RECEIVED

District Health Officer No. 4

District File Number 445-532

Date Filed 4-24-45

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 C. H. [Signature]
Licensed Embalmer No. 4084
P. O. Address Farmington, 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 this body is not embalmed, fact should be so stated above.