

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1787
Do not use this space.

Copy
REC'D FEB 21 1939

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 10
 (c) City Fulton (d) Street No. State Hospital #1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. 8 mos. 19 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Maude Malone Satterwhite
 (a) Residence, No. #3 Marshall Ave (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF DK

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 29th 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>70</u>	<u>70</u>	<u>10</u>	<u>7</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. None
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co. Mo.

FATHER

13. NAME Wilson Malone
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co. Mo.

MOTHER

15. MAIDEN NAME Mary Jane Davies
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) State Hosp #1 Records Fulton Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Over Mo DATE Jan 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Greening Marshall Mo.

20. FILED Jan 7 1939 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/6th 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:30 p. m.

The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia 1/3/39

Other contributory causes of importance:
Chr. Myocarditis, Senile Pericarditis, Dehydration & Malnutrition

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) [Signature] M. D.
 (Address) State Hosp #1 Fulton Mo.

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 myself
....., Registered Apprentice No.
working under my personal supervision.

Signed

J. R. Lucey

Licensed Embalmer No. 323 E-

P. O. Address Marshall 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, above space should be left blank.