

FILED AUG 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 24552

Registration District No. 104

Primary Registration District No. 4176

Registrar's No. 27

1. PLACE OF DEATH
 (a) County Dunklin
 (b) City or town Malden Mo.
 (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 1
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Dunklin
 (c) City or town Malden
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? ✓ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Loren T. Ault
 (b) If veteran name war L
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 23. DATE OF DEATH: Month July day 10
 year 1944 hour 2 minute P. M.

4. Sex Male 5. Color W. 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Axie 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased Feb 17 1865
 (Month) (Day) (Year)

24. I hereby certify that I attended the deceased from Summer 1944 to July-10 1944
 that I last saw him alive on July 6 - 1944 19_____
 and that death occurred on the date and hour stated above.
 Immediate cause of death High Blood Pressure - Arterial about 107/60
Sclerosis

8. AGE: Years 79 Months 4 Days 23
 If less than one day hr. min.

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace Green Co. Ind.
 (City, town, or county) (State or foreign country)
 10. Usual occupation Timber worker

PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name John L. Ault
 13. Birthplace Ind.
 (City, town, or county) (State or foreign country)
 14. Maiden name May Ann Cooper
 15. Birthplace Ind.
 (City, town, or county) (State or foreign country)

16. (a) Informant Myrtle Ault Glover
 (b) Address 4162 Arsenal (W.) St. Malden
 17. (a) burial (b) Date thereof 7-11-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Malden
 18. (a) Signature of funeral director W L Craig
 (b) Address Malden
 19. (a) 7-31-44 (b) W L Elder
 (Date received local registrar) (Registrar's signature)

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)
 Means of injury _____
 23. Signature Homer Bell (M. D. or other) _____
 Address Malden Mo Date signed 7-13-44

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

RECEIVED

District Health Office No. 2,

District File Number 844-1923

Date Filed 8-10-44

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 H. R. Craig

Licensed Embalmer No. 14302

P. O. Address Malden Mass

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.