

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

No. 2  
1-2-43  
5-17-39  
1 X35897

State File No. \_\_\_\_\_

Registration District No. 336

Primary Registration District No. 6136

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shannon

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

(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No  
(Specify whether years, months or days)

In this community 32 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon

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

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James M. Malone

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Laura A. Malone

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased April 29th, 1856  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept, day 30th  
year 1945 hour 8 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from Aug 1 to Sept 23  
that I last saw him alive on SEPT 23 and that death occurred on the date and hour stated above.

8. AGE: Years 89 Months 5 Days 1  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death CHRONIC MYOCARDITIS

Due to SENILITY

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Not Known

13. Birthplace Not Known  
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 93d

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant J.A. Malone

(b) Address Birch Tree, Mo

17. (a) Burial Bethelton Cem (b) Date thereof Oct, 3rd 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethelton Cem

18. (a) Signature of funeral director John J. Mean

(b) Address Mountain View Mo

19. (a) 10-27-45 (b) Malcolm R. Allen  
(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) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Laver Hampton (M. D. or other) D.O.

Address Summersville Date signed Oct 2

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

1495

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**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 John F. Amear

Licensed Embalmer No. 3516

P. O. Address Newton 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.**