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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED JUL 10 1946**  
**STANDARD CERTIFICATE OF DEATH**

20859

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

Registration District No. 170

Primary Registration District No. 30335625

Registrar's No. 4999

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

**1. PLACE OF DEATH:**

(a) County LACLEDE

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

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

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

In this community 30 DAYS  
years, months or days)

**3. (a) PRINT FULL NAME** SALLIE R. MALONE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: JUNE 5 1974  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>72</u>		<u>8</u>	hr. _____ min. _____

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

10. Usual occupation none

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

**MOTHER FATHER**

12. Name MACE WOODS

13. Birthplace US  
(City, town, or county) (State or foreign country)

14. Maiden name MARY ROBINSON

15. Birthplace US  
(City, town, or county) (State or foreign country)

16. (a) Informant Jan Malone

(b) Address NEW BURE MO

17. (a) Removal (b) Date thereof 6-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DIXON MO

18. (a) Signature of funeral director Fred Silbert

(b) Address DIXON MO

19. (a) 6-15-1946 (b) Dr. Frankburger  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County LACLEDE

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

(d) Street No. SLEEPER MO  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JUNE day 13  
year 1946 hour about 12 minute NOON M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death DROWNED

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**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) homicide

(b) Date of occurrence 6-13-46

(c) Where did injury occur? SMITH SLEEPER MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
IN CREEK ON FARM  
(Specify type of place)

While at work? NO (e) Means of injury \_\_\_\_\_

23. Signature Dr. Frankburger (M. D. or other) 13  
Address Leland MO Date signed 6/13/46

Received ..... 7-5-46

Laclede County Health Unit

File No. .... 6-46-97

Date Filed ..... 7-8-46

FEB 17 1949

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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

*R. Palmer*

Licensed Embalmer No. *1161*

P. O. Address

*Lebanon 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.