No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 30822

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

**1. PLACE OF DEATH:**

(a) County LACLEDE

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

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community ALWAYS

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County LACLEDE

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

(d) Street No. WALLACE HOSPITAL
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME LANNIE LEROY MALONE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased SEPT (Month) 28 (Day) 8 PM 1946 (Year)

8. AGE: Years | Months | Days | If less than one day 18 hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name ROSS MALONE

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

MOTHER 14. Maiden name MARJORIE ANN WOOD

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

16. (a) Informant ROSS MALONE

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-30-46 (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) Oct 5, 1946 (Date received local registrar) (b) Org Frankenberger (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month SEPT day 29 year 1946 hour 1:45 minute P M.

21. I hereby certify that I attended the deceased from 28 Sept 1946 to 29 Sept 1946 that I last saw him alive on 29 Sept 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Heart Disease — Duration 18 hr.

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Lewis Jenkins M.D. (M. D. or other)

Address Lebanon Mo Date signed Oct 4/46.

157E

152 (Licensed Embalmer's Statement on Reverse Side)

Received 10-8-46

Laclede County Health Unit

File No. 9-46-140

Date Filed ~~10-8-56~~

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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 O 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.**