

FILED MAR 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7098**

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hospital</u>		<u>405 Fletcher</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Dora</u>	b. (Middle)	c. (Last) <u>Malone</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Feb. 24 1949</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 12-1882</u>	9. AGE (In years last birthday) <u>66</u>	10. UNDER 1 YEAR Days <u>2</u>	11. UNDER 12 HRS. Hour <u>12</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>White County, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Calvin Harris</u>	13b. MOTHER'S MAIDEN NAME <u>Lou Womack</u>	14. NAME OF HUSBAND OR WIFE <u>George Malone, dec.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME <u>Dora Malone</u>	ADDRESS <u>405 Fletcher, Sikeston</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia, Hypostatic</u>		<u>1 week</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tuberculosis, Pulmonary</u> <u>20 yrs-</u> DUE TO (c) <u>Hemorrhage, duodenal thyroid</u> <u>2 years-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Abscess, Supraclavicular</u>			<u>3 months</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>MO2X</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec 1949, to Death, 1949, that I last saw the deceased alive on 24 Feb, 1949, and that death occurred at 11:50 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles J. Greenhill</u>	23b. ADDRESS <u>Sikeston Mo</u>	23c. DATE SIGNED <u>25 Feb '49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>26 Feb. 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hills Burrough</u>	24d. LOCATION (City, town, or county) (State) <u>Hillsborough, Ill</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 26 49</u>	REGISTRAR'S SIGNATURE <u>Mrs. T. F. Henry</u>	303	25. FUNERAL DIRECTOR'S SIGNATURE <u>Taylor Funeral Home Sikeston Mo</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0052

RECEIVED

District Health Office No. 2

District File Number 349-329

Date Filed 3-1-49

349 1949

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 25

[Signature] Student Embalmer No. _____
working under my personal supervision

Student [Signature] Student Embalmer
Signed James M. Scott
Licensed Embalmer No. 4350
P. O. Address East Linn, 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.