

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024285
STATE FILE NUMBER

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| FILED JUL 14 1958 | | Registration District No. 333 | | Primary Registration District No. 3074 | | Registrar's No. 117 | |
| 1. PLACE OF DEATH a. COUNTY Scott | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott /1003 | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Sikeston 09230 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hosp. | | | Length of stay in 1b 19 Days | | d. STREET ADDRESS (If outside, give location) 221 W. Malone | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Earl Middle J. Last Malone | | | | 4. DATE OF DEATH Month 6 Day 15 Year 1958 | | | |
| 5. SEX Male ? | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-13-1885 | | 9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Property Owner | | 11. BIRTHPLACE (City and state or country) Sikeston, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Dr. E. J. Malone | | | | 14. MOTHER'S MAIDEN NAME Nora Kirby | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT John R. Malone Address Sikeston, Missouri | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) ART. SCLEROTIC HEART Dis | |
| | | | | | | DUE TO (c) 4200 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| CER. - VASCULAR ACCIDENT (EMBOLYS) | | | | | | | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____ | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| | | | | Sikeston, Mo | | SCOTT MO | |
| 21. I attended the deceased from 5.28.58 to 6.15.58 and last saw her alive on 6.15.58 Death occurred at 4:45 pm on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Carl G. - 10 pp (Degree or title) | | | | 22b. ADDRESS Mo. Sikeston, Mo | | 22c. DATE SIGNED 6.16.58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 6-18-58 | 23c. NAME OF CEMETERY OR CREMATORY City | | 23d. LOCATION (City, town, or county) (State) Sikeston MO | | |
| 24. FUNERAL DIRECTOR Welch Funeral Home - Sikeston Mo. ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. 7-3-58 | | 26. REGISTRAR'S SIGNATURE Mrs. Ella Hunter | |

(Licensed Embolmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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DATE RECEIVED 7-8-58

SCOTT CO. HEALTH DEPT.

FILE NO. 758-~~58~~ 158

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 34

P. O. Address Stanton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.