

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025070

STATE FILE NUMBER

FILED JUL 17 1958 Registration District No. 104 Primary Registration District No. 4176 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <b>DUNKLIN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DUNKLIN</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MALDEN</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MALDEN</b> <b>03510</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>None</b>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>FANNIE</b> First <b>MAE</b> Middle <b>WALKER</b> Last				4. DATE OF DEATH <b>JUNE</b> " <b>25</b> 19 <b>58</b> Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1882</b>		9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>ANNA? ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM PIPPIN</b>				14. MOTHER'S MAIDEN NAME <b>PARALEE PIPPIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>Mrs Jettie James, Malden, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____	
						DUE TO (c) _____	
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"/>	
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	
21. I attended the deceased from <b>3-25-58</b> to <b>6-25-58</b> and last saw <sup>her</sup> him alive on <b>6-25-58</b> Death occurred at <b>3:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Agnes Egan MD</b>				22b. ADDRESS <b>Malden Mo</b>		22c. DATE SIGNED <b>7-9-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 27, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Malden, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>T C Knight Malden, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-12-58</b>		26. REGISTRAR'S SIGNATURE <b>J. D. Schuman</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare  
Public  
Service  
351  
300  
1-56  
All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED DUNKLIN COUNTY HEALTH  
DEPARTMENT 7-13-58  
COUNTY FILE NUMBER 758-17

JUL 18 1958

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 *Wallace R. Knight*

Licensed Embalmer No. *A.S. 822 Falmo*  
P. O. Address *Poplar B*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.