

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS OCT 8 1959

59-031401
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 4025 Registrar's No. 79

1. PLACE OF DEATH a. COUNTY <u>Barry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Barry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wheaton, Mo.</u>		Length of stay in lb <u>4 yrs.</u>	c. CITY OR TOWN <u>Wheaton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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) First <u>Gertrude</u> Middle _____ Last <u>Malone</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>2</u> Days _____	IF UNDER 24 HR Hours _____ 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 <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Chesterhill, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>Jonathan Morris</u>	13b. MOTHER'S MAIDEN NAME <u>Leah Guarawear</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Malone</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Melva Hayden</u> Address <u>Wheaton, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>Pulmonary Congestion-Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>In advanced Pulmonary</u>	
	DUE TO (c) <u>Tuberculosis.</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 8-27-59 to 9-28-59 and last saw her/him alive on 9-28-59
 Death occurred at 9-28-59 2:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles Price MD</u> (Degree or title)	22b. ADDRESS <u>Cassville, Missouri</u>	22c. DATE SIGNED <u>9-29-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-30-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Pleasant</u>	23d. LOCATION (City, town, or county) (State) <u>Butterfield, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. Morris Poque</u> ADDRESS <u>Wheaton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 2-59</u>	26. REGISTRAR'S SIGNATURE <u>Grace Williams</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 23 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James Kenneth DeWitt

Licensed Embalmer No. 4767

P. O. Address Wheaton, Ill.

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.