

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033629

FILED VS SEP 7 1960

Registration District No. 366 Primary Registration District No. _____ Registrar's No. 77

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Washington</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wash.</u>				
-b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Concord</u>		Length of stay in lb <u>22 years</u>		c. CITY OR TOWN <u>Mineral Point</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9 mi SE Potosi, Mo.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Osee</u> Middle <u>Edney</u> Last <u>Malone</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-77</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farming</u>		11. BIRTHPLACE (City and state or country) <u>City(unknown) Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Sidney D. Malone</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Eldridge</u>		14. NAME OF HUSBAND OR WIFE <u>Lettie R. Malone</u>			
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>494-07-8498</u>		17. INFORMANT Address <u>Lettie Malone, Mineral Point, Mo.</u>				
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>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>	
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) <u>Chronic Myocarditis - Arterio sclerosis</u>					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			
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 <u>Aug. 26-1960</u> to <u>Sept-1-1960</u> and last saw him alive on <u>Aug. 26-1960</u> . Death occurred at <u>12:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Joseph L. P. Luman, M.D.</u>				22b. ADDRESS <u>Potosi, Mo.</u>		22c. DATE SIGNED <u>9-2-1960</u>		
23a. BURIAL, CREMATION, RE-MOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. STATE		
<u>Burial</u>	<u>9-3-1960</u>	<u>Hopewell</u>		<u>Mineral Point, Mo.</u>		<u>Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>SPARKS Potosi, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>9/2/60</u>		26. REGISTRAR'S SIGNATURE <u>Herbert Randal</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Ronald Sparks*

Licensed Embalmer No. 4819
301 East
P. O. Address Potosi, Mis

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.