

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033246

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. **46**

Primary Registration District No. **3026**

Registrar's No. **454**

FILED SEP 19 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 3yrs	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1902 Lake Drive		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1902 Lake Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last LUCY BELLE MALONE			4. DATE OF DEATH Month Day Year Sept. 9, 1961
5. SEX Female	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 Aug. 25, 1890
9. AGE (last birthday) 71		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Grand Berry, Texas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Horace S. Phillips	13b. MOTHER'S MAIDEN NAME Nellie Lincoln
14. NAME OF HUSBAND OR WIFE Carl S. Malone dec.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None
17. INFORMANT Miss Ethel K. Phillips		Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paroxysmal Atrial Fibrillation			INTERVAL BETWEEN ONSET AND DEATH 1 yr
DUE TO (b) Arteriosclerotic Heart Disease			5 yr
DUE TO (c)			
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
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 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 6-1-61 to 9-8-61 and last saw her him alive on 8-15-61 Death occurred at 4 am on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles E. Randall MD		22b. ADDRESS 10901 Winner Rd Indep.	22c. DATE SIGNED 9/9/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept 11, 1961	23c. NAME OF CEMETERY OR CREMATORY Edgemont Cem.	23d. LOCATION (City, town, or county) (State) Anniston, Alabama.
24. FUNERAL DIRECTOR OTT & MITCHELL		ADDRESS INDEP, MO.	25. DATE RECD. BY LOCAL REG. 9-11-61 26. REGISTRAR'S SIGNATURE Alba L. Craig

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 11 1961

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 *[Handwritten Signature]*

Licensed Embalmer No. 3156

P. O. Address *[Handwritten Address]*

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.