

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033356

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 360

**FILED SEP 3 1963**

VS 300  
Rev. 4/59

0941  
20942

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4 0  
5 1  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in lb <b>1 Wk.</b>	c. CITY OR TOWN <b>Flat River</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>Bonne Terre Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>302 Roosevelt St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>M. ALDEN MALONE</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>25,</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Supply Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lead</b>	9. AGE (last birthday) <b>50</b> IF UNDER 1 YEAR: Months <b>7</b> Days <b>10</b> IF UNDER 24 HR: Hours <b></b> Min. <b></b>
11. BIRTHPLACE (City and state or country) <b>Bonne Terre, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Herbert Malone</b>		13b. MOTHER'S MAIDEN NAME <b>Ardelia McMullin</b>	14. NAME OF HUSBAND OR WIFE <b>Hallie (Ezell) Malone</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of <b>yes War # 2</b>		16. SOCIAL SECURITY NO. <b>9</b>	
17. INFORMANT <b>Hallie Malone Flat River, Mo.</b>			Address
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>Chronic myocarditis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7-8 years</b>
DUE TO (b) <b>Obscure connective tissue disease.</b>			
DUE TO (c) <b></b>			
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 checked="" 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 <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>			
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>8/18/63</b> to <b>8/25/63</b> and last saw him alive on <b>8/25/63</b> . Death occurred at <b>5:30</b> <b>A</b> .m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>Bonne Terre, Missouri</b>	22c. DATE SIGNED <b>8/26/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/28/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Francois Memo.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Francois Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Murphy L. Sparks Flat River, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug. 26, 1963</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE BLACK INK OR TYPEWRITER RIBBON

SEP 6 1963

DEC 24 1963

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 Murphy L. Spurr

Licensed Embalmer No. 4236

P. O. Address St. Louis, Mo

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.