

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11323

1. PLACE OF DEATH

County..... Dekalb Registration District No. 264
 Township..... Grant Primary Registration District No. 5367
 City..... ~~Wright~~ (No.) St. Ward)

2. FULL NAME..... Rebecca Mallory.....

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX - F. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edgar Mallory

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5th 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 8 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY) KY

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY) Unknown

14. INFORMANT Ed Mallory
 (Address) Fairport No.

15. FILED Apr 20 1927 9 Mrs. Kessler Hines
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1927 to April 16 1927
 that I last saw her alive on April 16 1927, and that death occurred, on the date stated above, at 3 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation
90A (duration) 20 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 90A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. A. Chey M. D.
 , 19 (Address) Fairport No

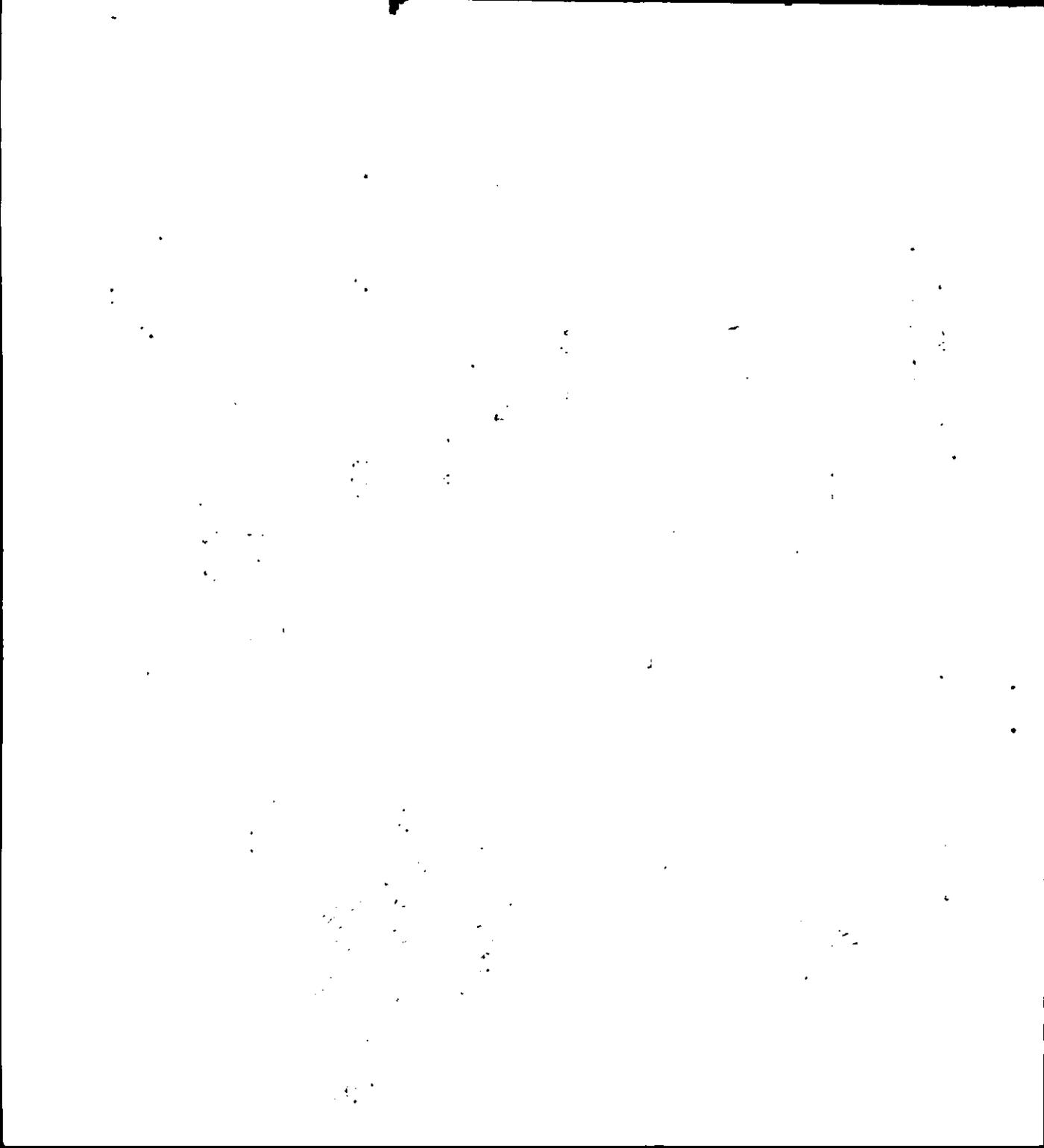
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview Cemetery DATE OF BURIAL Apr 18 1927

20. UNDERTAKER U. G. Pilcher ADDRESS Mayville Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

26 1927



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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County DeKalb

Registration District No. 364

Township Grant

Primary Registration District No. 5567

City..... (No.....).....St.....Ward)

File No.....

Registered No.....

2. FULL NAME

Rebecca Malloy

(a) Residence. No.....St.....Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

D

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN); (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY)

14.

INFORMANT.....

(Address).....

15.

FILED Apr 29 1927

Mrs. Keefer Dimes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April 16 1927

17.

I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

SUPPLEMENTAL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MAY 11 1955
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.