NOV 26 1927

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

Do not use this space.

31175

1. PLACE OF DEATH
County: Phelps
Township: Arlington
City: ..... (No. ....., ..... St. ..... Ward)
Registration District No. 676
Primary Registration District No. 5-8 oc
File No. .....
Registered No. 18

2. FULL NAME: Margaret Jane Malone

(a) Residence. No. Newburg Mo St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. 1 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Malone

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 11 1849

7. AGE: Years 78 | Months 10 | Days 18 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: 1861
(b) General nature of industry, business, or establishment in which employed (or employer): 144
(c) Name of employer: 07

9. BIRTHPLACE (CITY OR TOWN): Phelps Co
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: John Hance
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Mo
(STATE OR COUNTRY)

14. INFORMANT: Jas H Malone
(Address): Newburg Mo

15. FILED: 10/29, 1927 B F Smith
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): 10/29 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1927, to Oct 10, 1927, that I last saw h. alive on Sept 30, 19....., and that death occurred, on the date stated above, at 2.45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dil Heart
following Chronic Cirrh
+ injury from 37 3
yrs standing (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 0
(duration) yrs. mos. ds.

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) B F Smith, M. D
10/30 1927 (Address) Newburg Mo

*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: Kennett Cemetery
DATE OF BURIAL: 10/30 1927

20. UNDERTAKER: R Mull
ADDRESS: Rolla Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Phelps — Registration District No. 676 — File No.

Township Arlington — Primary Registration District No. 5896 — Registered No. 18

City (No. , St. Ward)

2. FULL NAME Margaret Jane Malone

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| F | W | W |

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. or min. |
|---|---|---|---|---|
| | | | | |

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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. X FILED 1/12, 1928 B T Dunn REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 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:
acute Bil Heart following injury of 3 years standing caused by a fall. X
Broken hip (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

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, or HOMICIDAL.

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

SUPPLEMENTARY

5-31175