

Dr. A. M. ...  
 DEPT OCT 21 1938

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

32456  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Gascon Registration District No. 411  
 (b) Township Galena Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
 (c) City Gasport (d) Street No. W. Johns Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Edna L. Mallory 461  
 (a) Residence, No. 615 Empire St St. Mo  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF T. Arthur Mallory  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6-1894  
 7. AGE YEARS 43 MONTHS 10 DAYS 1 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7- 1938

I HEREBY CERTIFY That I attended deceased from Sept 1 5:30 to Sept 7 7:45, 1938  
 I last saw her alive on Sept 7 1938. Death is said to have occurred on the date stated above, at 1:45 m.  
 The principal cause of death and related causes of importance were as follows:

Heart failure Date of onset \_\_\_\_\_  
stroke

Other contributory causes of importance:  
Surgical operation in the abdomen  
Thyroidectomy  
Thyroidectomy  
 Name of operation Thyroidectomy Date of Sept 6/38  
 What test confirmed diagnosis? Reber Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) W. Mitchell Grey M.D.  
Gasport, Mo. (Address)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington City, D.C.  
 FATHER 13. NAME Nathaniel M. Myers  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record  
 MOTHER 15. MAIDEN NAME Sarah Comstock  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record  
 17. INFORMANT T. A. Mallory  
 (ADDRESS) 615 Empire  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Memorial DATE Sept 9 38  
 19. FUNERAL DIRECTOR (NAME) Stonhill-Dillon  
 (ADDRESS) 305 W 4th St  
 20. FILED 9-10 1938 Ed. J. ... Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

66E

RECEIVED

District Health Officer No. 6,

District File Number 6-38318

Date Filed 10-11-38

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, .....

*David Dillon*

or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*David Dillon*

Licensed Embalmer No.....

3898

P. O. Address.....

*Joplin 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7

32456

Do not use this space.

1. PLACE OF DEATH

(a) County Gasper Registration District No. \_\_\_\_\_  
 (b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (c) City Joplin (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Edna K. Mallory

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(write the word)

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.
	<u>43</u>	<u>10</u>	<u>1</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7, 1928

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_ to \_\_\_\_\_, 19\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Heart failure + shock Date of onset \_\_\_\_\_

Other contributory causes of importance:

Spinal operation

Laparotomy + oophorectomy

Name of operator \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. Mitchell Gregg, M. D.

(Address) Joplin

SUPPLEMENTARY

REGISTRARS SMALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-32456