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.

RECEIVED SEP 22 1939

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

Do not use this space.

File No. 29593

Registered No. 16

1. PLACE OF DEATH
County: Linn
Registration District No. 488
Primary Registration District No. 4321
Township:
City: Brookfield (No. ..... St. ..... Ward)

2. FULL NAME: Infant Malloy

(a) Residence, No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug. 10 - 1939

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
0	0	0	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as silk mill, 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): Buckln Mo

FATHER
13. NAME: Dont Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): .....

MOTHER
15. MAIDEN NAME: Catherine Malloy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Brookfield Mo

17. INFORMANT (ADDRESS): Russel Malloy Brookfield Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Brookfield Cem DATE: Aug 11, 1939

19. UNDERTAKER (ADDRESS): Malloy B & D Brookfield Mo

20. FILED: Aug 11, 1939 J. L. Cantwell, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug 10, 1939

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:

	Date of onset
Premature Birth	

Other contributory causes of importance:

Criminal Abortion	

Name of operation ..... 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) J. L. Cantwell, M. D.
(Address) Buckln Mo

National Health Survey No. 39,
939-1226