

Registration District No. **85**

Primary Registration District No. **1001**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6029 Meade St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years
(Specify whether years, months or days)
In this community 40 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Sarah Elizabeth Malotte **430**

8. (b) If veteran, name war ✓ 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife A. J. Malotte 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept. 26, 1955
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>9</u>	<u>15</u>	hr. _____ min.

9. Birthplace Platte County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name James McAlexander

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Diona Hubbard

15. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ora Wahlgren
(b) Address 6029 Meade St.

17. (a) Burial (b) Date thereof 7-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ht. Auburn Cem. Clark Mortuary

18. (a) Signature of funeral director 5025 King Hill Ave.
(b) Address

19. (a) July 13 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 6029 Meade St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1940 hour 3 minute 45 p. M.

21. I hereby certify that I attended the deceased from May 39, 1939 to July 10, 1940
that I last saw him alive on July 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 1 1/2 yrs
Chronic Arteriosclerosis
Chronic Arterial Hypertension 1 yr

Due to _____

Due to _____

Other conditions 95%
(Include pregnancy within 3 months of death)

Major findings: Of operations ✓

Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 85 (Specify type of place) _____
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address 5004 1/2 King Hill Date signed 7/17/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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, ~~on~~ July 11, 19

....., Registered Apprentice No.

working under my personal supervision.

Signed

Earl A. Clark

Licensed Embalmer No. 3476

P. O. Address St. Joseph, 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.