

BUREAU OF THE CENSUS
FILED JAN 10 1941
318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42499

State File No. _____

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 968

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

1. PLACE OF DEATH: **GREENE**

(a) County: GREENE

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. JOHNS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days _____

3. (a) PRINT FULL NAME: ALTHA HOGUE MALENOWSKY

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Female

5. Color & race: White

6. (a) Single, widowed, married, divorced: married

6. (c) Age of husband or wife if alive: 39 years

7. Birth date of deceased: March 25 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 8 Days 7 hr. _____ min. _____

9. Birthplace: Unknown Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: House wife

11. Industry or business: In home

12. Name: Louis Hogue

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

14. Maiden name: Unknown Pa

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

16. (a) Informant: W. H. Malenowsky

(b) Address: Willard Mo

17. (a) Burial (b) Date thereof: Dec 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Roberson Home

18. (a) Signature of funeral director: Springfield, Mo

(b) Address: _____

19. (a) 12-4-40 (b) D. W. E. Handley, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Greene

(c) City or town: Willard
(If outside city or town limits, write "RURAL")

(d) Street No.: R. F. D. # 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6 year 1940 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from Nov 23, 1940, to Dec 2, 1940, that I last saw her alive on Dec 2, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic heart disease
Chd Myocarditis

Due to: Cardiac decompensation

Due to: rheumatic heart disease

Other conditions: _____
(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? AVIATION
While at work? _____ (Specify type of place) (e) Means of injury: _____

Signature: Ambruse (M. D. or other) _____
Address: Springfield Mo Date signed: 12-2-40

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

Signed Wm Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.