

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43632

JAN 25 1941
Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 248

1. PLACE OF DEATH:
(a) County Waukegan
(b) City or town Moberly
(c) Name of hospital or institution: Woodland Hosp.
(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) 1

3. (a) PRINT FULL NAME CECIL T. MALLORY
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex M 5. Color or race W
6. (b) Name of husband or wife MAYDRE MALLORY
6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased SEPT 19 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
37 1 10 - hr. - min.

9. Birthplace MONROE Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name MARSHALL MALLORY

13. Birthplace MONROE Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name ADA TIMBERG

15. Birthplace MONROE Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ray Gaines

(b) Address Madison, Mo.

17. (a) Burial (b) Date thereof DEC. 19 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MADISON Mo.

18. (a) Signature of funeral director Spencer Blalock

(b) Address Paris, Mo.

19. (a) Dec 1-40 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County MONROE
(c) City or town RURAL R.F.D. #3
(If outside city or town limits, write "RURAL")
(d) Street No. 4 mi. North of Madison
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 29
year 1940 hour 8:15 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 18, 1940, to Nov. 29, 1940;
that I last saw him alive on Nov. 29, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pulmonary embolism</u>	<u>2 days</u>
Due to <u>Acute perforative appendicitis and peritonitis</u>	<u>13 days</u>
Due to _____	_____
Other conditions _____ (Include pregnancy within 3 months of death)	_____

Major findings: acute perforative appendicitis with peritonitis
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? At home
While at work? _____ (Specify type of place) (e) Means of injury _____
28. Signature R. D. Streeton M.D. (M. D. or other) _____
Address Moberly Mo Date signed Nov. 29/40

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.

MOTHER FATHER

SEP -10 1947

RECEIVED

District Health Officer No. 10

District File Number 1-41-15-9

Date Filed JAN 16 1947

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.....

Licensed Embalmer No.....

P. O. Address.....

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.