

FILED FEB 4 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1994

Registrar's No. 33

Registration District No. 184

Primary Registration District No. 5256

## 1. PLACE OF DEATH:

- (a) County Christian  
 (b) City or town Highlandville R.R.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Road N. Salloway  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 20 yr.  
 years, months or days)

3. (a) PRINT FULL NAME Charles A. Mallonee

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Ellen Mallonee 6. (c) Age of husband or wife if alive 70 years7. Birth date of deceased July 12 1868  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
73 5 11 hr. min.9. Birthplace Tennessee  
(City, town, or county) (State or foreign country)10. Usual occupation Merchant

11. Industry or business \_\_\_\_\_

12. Name Thos Mallonee13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)14. Maiden name Mary Mallonee15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. C. A. Mallonee(b) Address Highlandville Mo17. (a) Buried (b) Date thereof Dec 26-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wine Hill18. (a) Signature of funeral director T. B. Chabbin(b) Address Ozark Mo.19. (a) Jan 21 1942 (b) Loretta Leonard  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County Christian  
 (c) City or town Highlandville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23  
year 1941 hour 12 minute 10 P. M.21. I hereby certify that I attended the deceased from  
Nov. 28, 1941 to Dec 23, 1941;that I last saw him alive on Dec. 30, 1941  
and that death occurred on the date and hour stated above.Immediate cause of death Paresis of 13th Cerv. V  
Extradural

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Of autopsy \_\_\_\_\_

Of autopsy \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. H. Wade (M. D. or other) \_\_\_\_\_Address Ozark Mo. Date signed 12-24-41

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

170

RECEIVED

District Health Officer No. 6,

District File Number 142-147

Date Filed JAN 28 1942

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 F. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1994

Registration District No. 184

Primary Registration District No. 5256

Registrar's No. ....

1. PLACE OF DEATH: Christian Highlandville  
 (a) County.....  
 (b) City or town.....  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution.....  
 (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 Charles U. Mallonee  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased July 12 1866  
 (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 14 (If less than one day)..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
 (Burial, cremation, or removal)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State..... (b) County.....  
 (c) City or town..... (If outside city or town limits, write "RURAL")  
 (d) Street No..... (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July Day 12 Year 1941 hour..... minute..... M.  
 21. I hereby certify that I attended the deceased from..... 19.....  
 that I last saw him..... live on..... 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Due to analysis of both femur cerebral hemorrhage  
 Due to.....  
 Other conditions..... (Include pregnancy within 3 months of death)

Major findings:  
 Of operations..... 83a'  
 Of autopsy.....

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?..... (Specify type of place) (e) Means of injury.....  
 23. Signature..... (M. D. or other)  
 Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

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

