

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 153

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(c) Name of hospital or institution: State Hosp # 22
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 yrs 8 mos
In this community 4 yrs 8 mos
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew
(c) City or town Savannah Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Homer D Malson

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nellie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 19 1882
(Month) (Day) (Year)

8. AGE: Years 60 Months 1 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Nestor Malson

13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

14. Maiden name Jarsh Wood

15. Birthplace Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Wife, Nellie Malson

(b) Address Savannah Mo

17. (a) Burial (b) Date thereof 2-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn

18. (a) Signature of funeral director Therman & Son Inc
(b) Address 1946 Colborn St

19. (a) 2-1-43 (b) Rose Arroy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30
year 1943 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-1-43
1943 to 1-30 1943

that I last saw him alive on 1-30 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronche pneumonia 2 das
Duration _____

Due to _____

Due to _____

Other conditions Chronic Nephritis Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations 12/8
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? _____ (Specify type of place) (e) Means of injury _____

23. Signature E H Magee (M.D. or other) _____

Address State Hosp # 2 Date signed 1-30-43

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, or by.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Robert D. Gaph

Licensed Embalmer No.

3308

P. O. Address.....

St. Joseph, Me.

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.