

FILED APR 8 1943
Registration District No. **2**

Primary Registration District No. **5018**

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

1. PLACE OF DEATH:
(a) County **Andrew**
(b) City or town **Bolckow (Rural) Platte**
(c) Name of hospital or institution: **Town**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 weeks** (Specify whether
In this community **3 weeks** years, months or days)

3. (a) PRINT FULL NAME **Eula Fay Mallory**
3. (b) If veteran, name war: **no** 3. (c) Social Security No. **no**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife: **no** 6. (c) Age of husband or wife if alive: **no** years
7. Birth date of deceased: **Dec 14 1942** (Month) (Day) (Year)

8. AGE: Years **2** Months **2** Days **18** If less than one day **no** hr. min.

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

10. Usual occupation: **no**

11. Industry or business **Buster Mallory**

12. Name **Wright County Missouri**

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

14. Maiden name **Wright County Missouri** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Bolckow Missouri**

(b) Address **Bolckow Missouri**

17. (a) **Burial Removal** (b) Date thereof **3-5-43** (Month) (Day) (Year)
(c) Place: burial or cremation **New Hope Cemetery**

18. (a) Signature of funeral director **Prig Funeral Home**

(b) Address **Marionville Mo.**

19. (a) **3/4/43** (Date received local registrar) (b) **J.H. Fitchman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Andrew**
(c) City or town **Bolckow Rural**
(d) Street No. **4 miles east** (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country: **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **mch** day **4** year **1943** hour **7:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **3/1-4/3**, 19 **to death**, 19 **and that death occurred on 3/14-43**, 19 **and that death occurred on the date and hour stated above.**

Immediate cause of death: **Lobar Pneumonia**
Due to: **Lobar Pneumonia**

Due to: **no**
Other conditions: **no** (Include pregnancy within 3 months of death)

Major findings: **no**
Of operations: **no**
Of autopsy: **no**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): **no**
(b) Date of occurrence: **no**
(c) Where did injury occur? (City or town) (County) (State): **no**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? (Specify type of place) (e) Means of injury: **no**

23. Signature **W. Logan Ward** (M. D. or other) Address **Bolckow Mo.** Date signed **3-4-43**

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Clem M. Price*.....
Licensed Embalmer No..... *1822*.....
P. O. Address..... *Mayville 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.