

FILED FEB 7 1944  
Registration District No. 41944

Primary Registration District No. 3012

Registrar's No. 5-

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Excelsior Spring Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Edward B Maltby  
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, widowed  
6. (b) Name of husband or wife Catherine Ann Maltby 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 9 1856  
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

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

MOTHER FATHER { 12. Name Rev. William Wesley Maltby  
13. Birthplace Ontario Co. N.Y.  
(City, town, or county) (State or foreign country)  
14. Maiden name Hannah Booth  
15. Birthplace Palmira N.Y.  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Burton Maltby  
(b) Address Liberty Mo

17. (a) Burial (b) Date thereof 1-12-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Mo

18. (a) Signature of funeral director O Gardner

(b) Address 119 E Frankl St Liberty

19. (a) 1-12-44 (b) Mrs Sadie Redman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay  
(c) City or town Liberty (If outside city or town limits, write "RURAL")  
(d) Street No. 112 E Frankl (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 Jan day 10th year 1944 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 10 1944 to Jan 10 1944  
that I last saw him alive on Jan 10 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 9 days

Due to Influenza

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

Other condition Advanced age  
(Include pregnancy within 3 months of death)

Major findings: Of operations 230  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J E Beard (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Date signed 1-12-44

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-3-44

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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 O. J. Cardey for

Licensed Embalmer No. 3934

P. O. Address Liberty 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.