

2  
41  
39  
26390

FILED MAY 24 1944  
Registration District No. ....

Primary Registration District No. 4173

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Douglas  
(b) City or town Ava  
(c) Name of hospital or institution: *Beaton*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community 65 yr  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas  
(c) City or town Ava  
(d) Street No.  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME William David Mallonee

3. (b) If veteran, name war No (c) Social Security No None

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

6. (b) Name of husband or wife Elsie Turner Mallonee 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased March 22, 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 4 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

12. Name William David Mallonee

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

14. Maiden name Unknown

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

16. (a) Informant *Leta Swanson*  
(b) Address *Almartha MO*

17. (a) Burial (b) Date thereof 4-29-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Murray

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Missouri

19. (a) 5-1-1944 (b) *Mrs. J. R. Spurlock*  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26  
year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 24 1944 to April 26 1944  
that I last saw him alive on April 26 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: *Brain aneurysm*

Due to

Due to

Other conditions: *83a!*  
(Include pregnancy within 3 months of death)

Major findings: Of operations

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?

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

23. Signature *J. R. Spurlock* (M. D. or other)

Address *MO* Date signed 5-1-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1056

RECEIVED

District Health Officer No. 6,  
District File Number 544-398  
Date Filed MAY 17 1944

**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.....

*H.B. Hutchison*

Licensed Embalmer No. 3431

P. O. Address.....

*Arw Md*

**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.**