S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 19 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Harrell 31219

State File No.

Registration District No. 170 Primary Registration District No. 3033 - 8 Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 47 DAYS (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County PULASKA 85

(c) City or town RICHLAND
(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 MALINDA CAROLINE EGAN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife M.W. EGAN

6. (c) Age of husband or wife if alive years

7. Birth date of deceased MAR (Month) 8 (Day) 1856 (Year)

8. AGE:

Years	Months	Days	If less than one day
88	4	27	hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name WM TYREE
13. Birthplace LACLEDE Co (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name POLLY ATWOOD
15. Birthplace (City, town, or county) U.S (State or foreign country)

16. (a) Informant Mrs Sam Robinson
(b) Address COMPETITION MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 (Month) -7- (Day) 44 (Year)

(c) Place: burial or cremation MT. CARNEY CEM.

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON

19. (a) 9-4-44 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 6-19- 1944, to 8-5- 1944, that I last saw her alive on 8-5- 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	6 da.
Due to	
Due to	
Other conditions Fracture L. femur (Include pregnancy within 3 months of death)	48 day

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 R E Harrell (M. D. or other) MD

Address Lebanon Mo Date signed 8-8-44

1040 (Licensed Embalmer's Statement on Reverse Side)

Received 9/6/44
Laclede County Health Unit
File No. 8-44-103
Date Filed 9/11/44

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 D A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.

S. No. 2B
0M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 170 Primary Registration District No. 3023 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(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)

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

3. (a) PRINT FULL NAME Malinda C Egan
3. (b) If veteran, name war
3. (c) Social Security No.

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

7. Birth date of deceased Mar. (Month) 8 (Day) 1856 (Year)

8. AGE: Years 88 Months 4 Days 2 If less than one day hr. min.

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

10. Usual occupation
11. Industry or business

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

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

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 5 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral hemorrhage 6 da
Due to 186a
Due to
Other conditions Fracture of femur 48 da
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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

22. If death was due to external causes, fill in the following: Fell in home while walking. 6-19-44
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence 6-19-44
(c) Where did injury occur? Richland (City or town) Mo (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home - walking fell down. (Specify type of place)
While at work? No (e) Means of injury

23. Signature R. E. Harell (M. D. or other) MD.
Address Lebanon, Mo Date signed 10-2-44

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

31219