S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Hogeboom

State File No. 41177

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 921

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: St. John's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 Days (Specify whether

In this community 4½ Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield (If outside city or town limits, write "RURAL")

(d) Street No. 1214 S. Fort (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Bessie L. Mallon

3. (b) If veteran, name war No

3. (c) Social Security No. UNK.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Steve Mallon

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

7. Birth date of deceased Dec. (Month) 3 (Day) 1887 (Year)

8. AGE: Years 57 Months 0 Days 12 If less than one day hr. min.

9. Birthplace Guthrie Center (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Manager

11. Industry or business Avon Products

FATHER
12. Name Andrew B. Price
13. Birthplace UNK. (City, town, or county) New Jersey (State or foreign country)

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

16. (a) Informant Steve Mallon

(b) Address Springfield, Mo.

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

(c) Place: burial or cremation Guthrie Center, Iowa

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo

19. (a) 12-16-44 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1944 hour 10 minute 10 p.M.

21. I hereby certify that I attended the deceased from Oct 29, 1943, to Dec 15, 1944 that I last saw her alive on Dec 15, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Liver (Metastatic	3 WKS
Due to Carcinoma of Right Breast	14 months
Due to	
Other conditions (Include pregnancy within 3 months of death) 50	
Major findings: Of operation Amputation Rt Breast 11-6-43	
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 [signature] (M. D. or other)

Address Springfield Mo Date signed 12-16-44

(Licensed Embalmer's Statement on Reverse Side)

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 L Dooley Gorman

Licensed Embalmer No. 7177

P. O. Address Springfield 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.

X