S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14486

State File No.

FILED APR 25 1945

Registration District No. 944 Primary Registration District No. 6075

Registrar's No. 372

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Farmington St Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo 1 day (Specify whether years, months or days)
In this community 4 mo 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Butler 94
(c) City or town Poplar Bluff
(If outside city or town limits, write "RURAL")
(d) Street No. 840 Vine Street
(If rural, give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FANNIE E. MALUGEN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F. 1

5. Color or race W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 3 (Day) 1870 (Year)

8. AGE: Years 74 Months 8 Days 11 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

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

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

16. (a) Informant Hospital Record
(b) Address State Hospital #4 Farmington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation Poplar Bluff Mo

18. (a) Signature of funeral director (Name)
(b) Address Poplar Bluff

19. (a) 4-19-45 (Date received local registrar) (b) Forrest Coleman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14 year 1945 hour 9:15 minute A M.

21. I hereby certify that I attended the deceased from Dec. 13, 1944 to April 14, 1945 that I last saw h. alive on April 14, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerosis generalized by marked	2 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Cerebral arteriosclerosis (Psychosis)	1 yr

Major findings:
Of operations
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 James T. Horton (M. D. or other)
Address Farmington Mo Date signed 4/14/45

1013 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 445-53

Date Filed 4-24-

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 Grover W Greer

Licensed Embalmer No. 2964

P. O. Address Poplar Bluff 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.