

No. 2
-5-43
-17-39
X38671

Registration District No. **275**

Primary Registration District No. **3053**

Registrar's No. **48**

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **Rolla**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Nelle M. Farland Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days** (Specify whether
In this community **8 days** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Osage**
(c) City or town **Rolla** (If outside city or town limits, write "RURAL")
(d) Street No. **Rt. 1** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

David M. Malan

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 **1**
6. (b) Name of husband or wife **James L. Malan**
6. (c) Age of husband or wife if alive **40** years
7. Birth date of deceased **Aug. 21 1919**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 5 28 hr. min.

9. Birthplace **Belle R.D. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business
12. Name **John A. Thompson**
13. Birthplace **Osage Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Pearl Francis**
15. Birthplace **Osage Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **James L. Malan**
(b) Address **Belle, Mo. R.D.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-28-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Francis Cemetery**

18. (a) Signature of funeral director **Clyde Morton**
(b) Address **Rolla, Mo.**

19. (a) **Feb. 21, 1946** (Date received local registrar) (b) **Mrs. Juanita Harvey** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **19**
year **1946** hour **6:00** minute **0** M.

21. I hereby certify that I attended the deceased from **Feb. 11**, 1946 to **Feb. 19**, 1946;
that I last saw her alive on **Feb. 19**, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Nephritis**
Due to _____
Due to _____

Other conditions **Pregnancy**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **13/18**

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?

While at work? _____ (Specify type of place) (e) Means of injury **0**
23. Signature **Dr. J. M. Farland** (M. D. or other) **2/21/46**
Address **Rolla, Mo.** Date signed _____

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

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

MOTHER FATHER

252

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

Vernon M. Morton
Helmut B. ...
3704 4125
Jefferson City, Mo.
Linn, Mo.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 275-

Primary Registration District No. 3059

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Phelps
 (b) City or town Rolla
 (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
 years, months or days)

3. (a) PRINT FULL NAME Larida Malan
 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 m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug 21 (Month) (Day) (Year)

8. AGE: Years 26 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 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) Mar 16, 1946 (Date received local registrar) (b) Mar Juanita Harvey (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 7 day _____ 1945 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
 Due to _____
 Other conditions _____ (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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

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

66699