

FILED APR 22 1946  
Registration District No. 205

Primary Registration District No. 5741

State File No. \_\_\_\_\_

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Wacon  
(b) City or town New Cambria Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: RR # 1, Rural Dist.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 45 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wacon  
(c) City or town New Cambria Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. RR # 1 (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26  
year 1946 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from Mar 20th 1946 to Mar 26 1946  
that I last saw him alive on Mar 24 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Hemorrhage Duration 6 PD

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations 4th  
Of autopsy no

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? \_\_\_\_\_

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

23. Signature Co. West (M. D. \_\_\_\_\_)  
Address New Cambria Mo. Date signed Mar 26 1946

3. (a) PRINT FULL NAME

ABRAHAM F. MALLOY  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Annada E. Malloy 6. (c) Age of husband or wife if alive 74 year  
7. Birth date of deceased April 15 1866 (Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Railroading

11. Industry or business Section Labor

12. Name W.A. Malloy

13. Birthplace Knott Co. Mo. (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 Annada E. Malloy

(b) Address New Cambria Mo.

17. (a) Burial (b) Date thereof Mar 28, 1946 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Cem.

18. (a) Signature of funeral director Person Funeral Service

(b) Address Buadlin Mo.

19. (a) 3/27/46 (b) Alman M. Killeland (Date received local registrar) (Registrar's signature)

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

RECEIVED  
District Health Officer No. 10  
District File Number 4-46-789  
Date Filed APR-1-9-1946

**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..... *E. A. Larson*  
Licensed Embalmer No. *4037*  
P. O. Address..... *Bucklin, 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.**