

Registration District No. 206

Primary Registration District No. 4317

Registrar's No. 161

1. PLACE OF DEATH:

(a) County MADISON
(b) City or town MARQUAND, Mo.
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)
(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 Mo (b) County MADISON
(c) City or town MARQUAND
(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 GEORGE R MALLOY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M I
6. (b) Name of husband or wife LOUISE MALLOY 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased Oct 5 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMOR

11. Industry or business _____

MOTHER FATHER

12. Name WILLIAM - MALLOY
13. Birthplace VIRGINIA
14. Maiden name ELLEN YOUNG
15. Birthplace VIRGINIA

16. (a) Informant E. B. Whitener
(b) Address Marquand

17. (a) BURIAL (b) Date thereof 7-7-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARQUAND

18. (a) Signature of funeral director E. B. Whitener

(b) Address Marquand, Mo.

19. (a) 7-7-1947 (b) Florence Nichols
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 6
year 1947 hour 9 minute a.m.

21. I hereby certify that I attended the deceased from JAN. 5th
1947, to JAN 6, 1947
that I last saw him alive on JAN 6, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency Duration undetermined

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 95C
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? 2

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Keith P. Hull (M. D. or other) D.O.
Address Judicktown, Mo. Date signed 7-7-46

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

62
0
0

RECEIVED

Health Officer No. 4
File Number 147-71
Date filed 1-13-47

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.....

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.