

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Excelsior Springs Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 1 day  
years, months or days)

3. (a) PRINT FULL NAME Dr. Burton Maltby  
3. (b) If veteran, name war World War I 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Inez Marens Maltby 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased July 7 1885  
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 22 If less than one day hr. min.

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

10. Usual occupation Medical Doctor

11. Industry or business \_\_\_\_\_

12. Name Edward B Maltby  
13. Birthplace Ligonier Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Murdoch  
15. Birthplace Bloomington Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edith Bickenson

(b) Address 114 N. Leonard St. Liberty

17. (a) Removal (b) Date thereof 1/29/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington, Mo.

18. (c) Signature of funeral director [Signature]

(b) Address 119 E. Franklin Liberty Mo.

19. (a) 2/10/47 (b) Baroline Hutchings  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24  
(c) City or town Liberty  
(If outside city or town limits, write "RURAL")  
(d) Street No. 518 W Kansas St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29  
year 1947 hour 8 minute 010 M.

21. I hereby certify that I attended the deceased from Oct 15 1947 to Jan 29 1947  
that I last saw him alive on Jan 29 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of Cornea  
Myasthenia Gravis  
Copropneumosis of liver  
Due to Coronary artery disease  
Duration \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy no 46K  
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 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs signed \_\_\_\_\_

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

4  
1  
1

MOTHER FATHER

PHYSICIAN

7-30-47

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-22-47

JUL 17 1947

MAY 26 1948

MAR 6 1948

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. 3934

P. O. Address Liberty, 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.