

FILED APR 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37431A

BIRTH NO. _____ REG. DIST. NO. 70 PRIMARY REG. DIST. NO. 5296 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY CLARK			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MISSOURI b. COUNTY CLARK			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wyaconda Township		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Luray, Missouri		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED a. (First) Lucy (Type or Print)			b. (Middle) I	c. (Last) Malone	4. DATE OF DEATH (Month) (Day) (Year) NOV. 5 1947	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH May 8 1897	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Daniel Johnston		13b. MOTHER'S MAIDEN NAME Leroy Fisher		14. NAME OF HUSBAND OR WIFE Larkin Malone		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Leroy Stevens		17. ADDRESS Luray, Mo		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)	MEDICAL CERTIFICATION Cerebral Hemorrhage Dizziness		INTERVAL BETWEEN ONSET AND DEATH		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from Jan 1, 1947, to Nov 5, 1947, that I last saw the deceased alive on Nov 4, 1947, and that death occurred at 2-4 m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) W. B. Bridges M.D.			23b. ADDRESS Kohokah Mo		23c. DATE SIGNED 4/16-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 7, 1947	24c. NAME OF CEMETERY OR CREMATORY Bethelam Cemetery	24d. LOCATION (City, town, or county) (State) Luray, Clark Co. Mo	25. FUNERAL DIRECTOR'S SIGNATURE Gerth Basket		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 7, 1947	24c. NAME OF CEMETERY OR CREMATORY Bethelam Cemetery	24d. LOCATION (City, town, or county) (State) Luray, Clark Co. Mo	25. FUNERAL DIRECTOR'S SIGNATURE Gerth Basket		
25. FUNERAL DIRECTOR'S SIGNATURE Gerth Basket	25. ADDRESS Wyaconda Mo	26. (Licensed Embalmer's Statement on Reverse Side)				

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

1947

MAY 1 1951

Date Received: APR 23 1951
DISTRICT HEALTH OFFICE #2
District File Number 4-51-801
Date Filed: APR 25 1951

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.

..... Student Embalmer No.....

Signed Geo. J. Bossett

Signed.....
Student Embalmer

Licensed Embalmer No. 1817

P. O. Address City Centre 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.