

No. 2  
1/47  
5-17-39

FILED MAY 25 1948

6092

Registrar's No. 105

Registration District No. 524

Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County **Saline**  
**Malta Bend, Mo.**  
(b) City or town **Grand Pass township, Rural**  
(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.....  
In this community **All her life**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) County **Missouri**  
**Malta Bend, Mo.**  
(b) County **Saline**  
(c) City or town **Grand Pass township, Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Jessie Beatrice Malter**

3. (b) If veteran, name war.....  
3. (c) Social Security No. **None**

4. Sex **Female**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **George J. Malter**  
6. (c) Age of husband or wife if alive **74** years  
7. Birth date of deceased **January 13th, 1879**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**69 4 4** hr. min.

9. Birthplace **Saline County, Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business.....

12. Name **John Henry Fulton**

13. Birthplace **Unknown Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Abenaid Silcott**

15. Birthplace **Adams County, Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **George J. Malter**

(b) Address **Malta Bend, Mo.**

17. (a) **Burial** (b) Date thereof **May 19, 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Malta Bend cemetery**

18. (a) Signature of funeral director **Campbell**  
(b) Address **Marshall, Mo.**

19. (a) **May 19, 1948** (b) **Sidney T. Bray**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **17**  
year **1948** hour **2** minutes **30** P. M.

21. I hereby certify that I attended the deceased from **April 15**, 19**48**, to **17 May**, 19**48**  
that I last saw her alive on **17 May**, 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac arrest**  
Due to **Myocardial infarction** 1 hour

Other conditions **Hypertension & arteriosclerosis**  
**Fractured hip 3 wks. ago**  
(Include pregnant within 3 months of death) **unknown**

Major findings:  
Of operations.....  
Of autopsy.....  
PHYSICIAN  
Underline the cause of which death should be reported statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....

23. 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 **D**

23. Signature **R. F. Lively, M.D.** (M. D. or other)  
Address **Marshall, Mo.** Date signed **5-18-48**

MOTHER FATHER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

INK—MAKE A PERMANENT RECORD

7

97  
9

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 5-24-42

OCT 2 1952

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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

AIKEN-LAWRENCE CLINIC  
MARSHALL, MO.

GEORGE A. AIKEN, M. D.  
JOHN R. LAWRENCE, M. D.  
JAMES A. REID, M. D.  
RICHARD F. AIKEN, M. D.

May 29, 1948

R. M. James, M.D.  
Special Agent, U.S.P.H.S  
Division of Health  
Jefferson City, Missouri

Dear Dr. James:

This is in explanation of Death Certificate of Mrs. Jessie B. Malter. Her terminal illness was obviously due to myocardial infarction. I believe this was incidental to the subcapital fracture of the hip rather than a sequel. The hip had been satisfactorily pinned three weeks prior to death and she had been up in a wheel chair for two and one-half weeks. She has had a known hypertension and arteriosclerosis of at least ten years duration. It was noted in taking family history that all member of her immediate family, numbering seven, died suddenly in a manner most suggestive of myocardial infarction.

I am returning the Supplementary Standard Certificate Of Death signed.

Yours very truly,

*R. F. Aiken, M.D.*

RFA/rs

Enc: 1

WRITE PLAINLY - USING

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15  
11  
11

S (2) 18368

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 105

Registration District No. 324

Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town rural  
(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)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jesse B. Malter

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 2 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 \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days \_\_\_\_\_ (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 June year 1948 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) \_\_\_\_\_

Duration

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

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

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

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature R. F. Aiken, M.D. (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S (2) 18 368

Journal

1835