

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37003  
3258

FILED AUG 21 1950

|  |                           |  |  |   |  |   |  |
|--|---------------------------|--|--|---|--|---|--|
| BIRTH NO. _____  |                           | REG. DIST. NO. <u>149</u>  |  | PRIMARY REG. DIST. NO. <u>1002</u>  |  | Registrar's No. _____   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Kansas City, Mo</u>   |                           | c. LENGTH OF STAY (In this place)<br><u>7D 7Hrs</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Walnut Grove, Mo</u>   |  | d. STREET ADDRESS (If rural, give location)<br><u>Rt. 3 039, 0 X</u>                |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Children's Mercy Hosp.</u>   |                           |  |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>James Franklin</u> b. (Middle) _____ c. (Last) <u>Maloney</u>  |                           |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>7 29 1950</u> |   |  |   |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Child</u>   | 8. DATE OF BIRTH<br><u>10-19-1948</u>                        | 9. AGE (In years last birthday)<br><u>1 6</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 2 HRS.<br>Hours _____ Min. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Denver, Colo</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                     |  |
| 13a. FATHER'S NAME<br><u>Wayne E. Maloney</u>  |                           | 13b. MOTHER'S MAIDEN NAME<br><u>Adeline Snowden</u>  |  | 14. NAME OF HUSBAND OR WIFE<br>_____  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                           | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ed. Beach, Snowden</u> ADDRESS <u>Walnut Grove, Mo.</u>   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  |                           | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculin meningitis</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>010X</u>                                 |  |
| II. OTHER SIGNIFICANT CONDITIONS*<br>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?<br>YES <input type="checkbox"/> NO <input checked="" 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"/>   |  | 21f. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>7-22</u> , 19 <u>50</u> , to <u>7-29</u> , 19 <u>50</u> that I last saw the deceased alive on <u>7-29</u> , 19 <u>50</u> and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. |                           |  |  |   |  |   |  |
| 23a. SIGNATURE <u>H. M. Gilkey, M.D.</u> (Degree or title)   |                           |  |  | 23b. ADDRESS <u>1624 Prof. Bldg.</u>  |  | 23c. DATE SIGNED <u>7-29-50</u>   |  |
| 24a. BURIAL CREMATION REMOVAL (Specify)<br><u>BURIAL</u>   |                           | 24b. DATE <u>7-30-50</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY _____  |  | 24d. LOCATION (City, town, or county) (State)<br><u>Mound Grove Mo.</u>             |  |
| DATE REC'D BY LOCAL REG. <u>7-30-50</u>  |                           | REGISTRAR'S SIGNATURE <u>Geraldine Helmer</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Melody - M. Gilkey - E. L. A. K.</u>  |  | ADDRESS <u>K.C., Mo.</u>  |  |

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

(Licensed Embalmer's Statement on Reverse Side)

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed May W. Kirkendall

Licensed Embalmer No. #4632

P. O. Address B. C. 5, 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.