

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **44215**

FILED JAN 9 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **242**

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Sikeston</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Sikeston</b> <b>1003</b>	
c. LENGTH OF STAY (In this place) <b>4 Hours</b>		d. STREET ADDRESS (If rural, give location) <b>137 Fifth Street</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hosp.</b>			

3. NAME OF DECEASED (Type or Print) <b>Malcolm</b>		a. (First) <b>H.</b>	b. (Middle)	c. (Last) <b>Monan</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>12-23-1952</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>3-26-1908</b>	9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operates</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Side Cafe</b>		11. BIRTHPLACE (State or foreign country) <b>Sikeston, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>T. H. Monan</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Henson</b>		14. NAME OF HUSBAND OR WIFE <b>Earue Heath Monan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>Larue Heath Monan, 137 5th</b>			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hr</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>---</b> DUE TO (c) <b>---</b>				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>---</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>---</b>				20. AUTOPSY? 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? <b>4201</b>					

22. I hereby certify that I attended the deceased from **12-23-1952** to **12-29-1952**, that I last saw the deceased alive on **12-22-1952**, and that death occurred at **3:55 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. D. Urban M.D.</b>		(Degree or title)		23b. ADDRESS <b>Sikeston</b>		23c. DATE SIGNED <b>12/29/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>December 26, 52</b>		24c. NAME OF CEMETERY OR CREMATORIUM <b>Memorial Park</b>		24d. LOCATION (City, town, or county) (State) <b>Sikeston Scott Mo.</b>	
DATE REC'D BY LOCAL REG. <b>12-29-52</b>		REGISTRAR'S SIGNATURE <b>Mrs. Della Hunter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Quilla Taylor</b>		ADDRESS <b>Sikeston Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JAN 5 1953  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 153-5

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.....  
Student Embalmer

Signed J. E. Millmiller  
Licensed Embalmer No. 4625

P. O. Address E. Prairie St.

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.