

FILED MAY 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15554**

BIRTH NO. 24059-54 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 433-A

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Newton	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Neosho	d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. LENGTH OF STAY (In this place) 6 days		e. STREET ADDRESS (If rural, give location) McKenny St. 2737	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bunge Hosp.			
3. NAME OF DECEASED (Type or Print) a. (First) Karla b. (Middle) Jo c. (Last) Malcolm.		4. DATE OF DEATH (Month) (Day) (Year) Apr 30 1954	
5. SEX f	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH April 23-54
9. AGE (In years last birthday) 6		10. MONTHS 6	11. DAYS 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Neosho, Mo.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Joe Bob Malcolm		13b. MOTHER'S MAIDEN NAME Joan Embrey	
14. NAME OF HUSBAND OR WIFE - - - - -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT'S SIGNATURE OR NAME Joan Malcolm		ADDRESS Neosho, 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 776X	
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) (m.)		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 April 23, 1954 , to April 30, 1954 , that I last saw the deceased alive on April 30, 1954 , and that death occurred at 1:10 a. m. , from the causes and on the date stated above.			
23a. SIGNATURE Paul Busch M.D. (Degree or title)		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 5/15/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 4-30-54	
24c. NAME OF CEMETERY OR CREMATORY - - - - -		24d. LOCATION (City, town, or county) (State) Neosho, Missouri	
DATE REC'D BY LOCAL REG. 5-19-54		REGISTRAR'S SIGNATURE Edith Williamson	
25. FUNERAL DIRECTOR'S SIGNATURE Orley Thompson		ADDRESS Neosho Mo	

(Licensed Embalmer's Statement of Reverse Side)

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

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.....
Signature of Student Embalmer

Signed.....
Ray P. Adams

Licensed Embalmer No. *4922*

P. O. Address *Hawaii, N.H.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.