

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35873**
Registrar's No. **9014**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY OR TOWN ST. LOUIS, Mo.	c. LENGTH OF STAY (In this place) 2 DAYS	c. CITY OR TOWN SULLIVAN	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKE'S HOSP		f. STREET ADDRESS (If rural, give location) 307 ELMONT ROAD	
3. NAME OF DECEASED a. (First) ROSA BELLE b. (Middle) _____ c. (Last) MALONE		4. DATE OF DEATH (Month) (Day) (Year) OCT 1 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 26, 1886
9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 7 Days 5	IF UNDER 24 HRS. Hours 7 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) MEDINA, OHIO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME CHARLES HOUTS		13b. MOTHER'S MAIDEN NAME RANDOLPH	14. NAME OF HUSBAND OR WIFE JOHN W. MALONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME JOHN MALONE SULLIVAN, MO. ADDRESS _____	
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) Cerebrovascular accident ANTECEDENT CAUSES DUE TO (b) Fracture of the neck of the left femur DUE TO (c) _____ OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	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.) home	21c. (CITY, TOWN, OR TOWNSHIP) 23 (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? OOD	
22. I hereby certify that I attended the deceased from 9-28-1956 , to 10-1-1956 , that I last saw the deceased alive on 9-30-1956 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Vern P. Blair Jr. M.D.		23b. ADDRESS 100 N. Euclid	23c. DATE SIGNED 10-1-56
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT 4, 1956	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
DATE REC'D BY LOCAL REG. OCT 2 1956	REGISTRAR'S SIGNATURE Charles Smith	25. FUNERAL DIRECTOR'S SIGNATURE Max Huleator ADDRESS Sullivan, Mo.	

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

Sullivan of Mo

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 *J. A. Dempsey*

Licensed Embalmer No. *4772*

P. O. Address *Sullivan, N.Y.*

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.