

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32561**

FILED OCT 1 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 179 PRIMARY REG. DIST. NO. 5669 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <u>Rural Hawk Point</u>		c. CITY OR TOWN <u>Rural</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>Life</u>		e. STREET ADDRESS (If rural, give location) <u>Farm Residence</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Farm 5mi west of Troy</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>William</u>	b. (Middle) <u>Frank</u>	c. (Last) <u>Mallan</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 23, 1957</u>
-------------------------------------	---------------------------	--------------------------	-------------------------	----------------------------------------------------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 14, 1880</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____	IF UNDER 2 HRS. Hours _____	Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Farming</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Lincoln Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				

13a. FATHER'S NAME <u>William Mallan</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Kallash</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes Mashek Mallan</u>
---------------------------------------------	------------------------------------------------------	-----------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give year or date of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Agnes M. Mallan, Troy, Mo. Rt #3</u>	ADDRESS <u>Troy, Mo. Rt #3</u>
-----------------------------------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------------	-----------------------------------

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY OCCLUSION</u>		<u>6 HOURS</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HT. DIS.</u> DUE TO (c) _____		<u>UNK</u>
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 <u>4200</u>	20. AUTOPSY? <u>2</u> 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) 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 4-12, 1956, to 9/23, 1957, that I last saw the deceased alive on 8-15, 1957, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Louis P. Healy, M.D.</u>	23b. ADDRESS <u>Troy, Missouri</u>	23c. DATE SIGNED <u>9/24/57</u>
--------------------------------------------------------------	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9/25/57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mashek Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lincoln Co. Missouri</u>
---------------------------------------------------------	--------------------------	-----------------------------------------------------------	---------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>9/26/57</u>	REGISTRAR'S SIGNATURE <u>Nell - L. Schoenlein</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kemper-Marsh Funeral Home</u>	ADDRESS <u>Troy, Mo.</u>
-----------------------------------------	---------------------------------------------------	-------------------------------------------------------------------	--------------------------

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

455

**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, JOE BY ..... Student Embalmer No.....

working under my personal supervision.:

Student.....  
Signature of Student Embalmer

Signed.....  
*Joseph J. Marsh*

Licensed Embalmer No...3932...

P. O. Address TROY, MISSOURI

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.