

THE DIVISION OF HEALTH OF MISSOURI 19735-58  
STANDARD CERTIFICATE OF DEATH

58-011989  
State File No. ....

FILED APR 9 1958

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 3673

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Jefferson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Barnhart		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 Lutheran Hospital		e. STREET ADDRESS (If rural, give location) Barnhart, Missouri					
3. NAME OF DECEASED (Type or Print) a. (First) Vickie		b. (Middle) -		c. (Last) Malcom			
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) no			
8. DATE OF BIRTH 3-30-58		9. AGE (In years last birthday) 1		10. UNDER 1 YEAR Months Days 21			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri			
13a. FATHER'S NAME Bobby Landon Malcom		13b. MOTHER'S MAIDEN NAME Donna Joyce Tarrant		14. NAME OF HUSBAND OR WIFE none			
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 Donna Malcom			
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) <i>premature res (22 wk gestation)</i> 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. 776x				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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)		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 <i>7-30</i> , 1958, to <i>4-1</i> , 1958, that I last saw the deceased alive on <i>4-1</i> , 1958, and that death occurred at <i>7:30 a.m.</i> , from the causes and on the date stated above.							
23a. SIGNATURE <i>D. Creel</i>		23b. ADDRESS <i>752 Hemway Ferry</i>		23c. DATE SIGNED <i>4-1-58</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <i>4-1-58</i>		24c. NAME OF CEMETERY OR CREMATORY BURGESS			
24d. LOCATION (City, town, or county) (State) ANTONIA MO. <del>MISSOURI</del>		25. FUNERAL DIRECTOR'S SIGNATURE HEILIGTAG					
DATE REC'D BY LOCAL REG. APR 1 58		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		ADDRESS IMPERIAL, MISSOURI.			

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed <sup>NOT</sup>

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmer Halbigtag*.....

Licensed Embalmer No. *357*.....

P. O. Address *Imperial*.....

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.