

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033357
STATE FILE NUMBER

FILED SEP 16 1958

Registration District No. 2174 Primary Registration District No. 3035 Registrar's No. 72

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1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lexington 0542
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1507 Franklin		Length of stay in lb 70 years	d. STREET ADDRESS (If outside, give location) 1507 Franklin
3. NAME OF DECEASED (Type or print) First Hannah Middle Mallot Last Mallot			4. DATE OF DEATH Month August Day 1 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1859
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Canada
13a. FATHER'S NAME Mathew Mahoney		13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Peter A. Mallot
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Florence Farrow, Lexington, Missouri.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			4500
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Lexington Mo	
20g. COUNTY Lexington		20h. STATE Mo	
21. I attended the deceased from 8/1/58 to _____ and last saw her/him alive on 8-1-58 Death occurred at 1:25 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jean Ward mal (Degree or title)		22b. ADDRESS Lexington Mo	22c. DATE SIGNED 8/18/58
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE August 4, 1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) Lexington, Missouri.
24. FUNERAL DIRECTOR Robert J. Temple Lexington, Missouri		25. DATE RECD. BY LOCAL REG. 9-3-58	26. REGISTRAR'S SIGNATURE Wm E. Eubank

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Ch. M. Keane*

Licensed Embalmer No. 2983
P. O. Address St. Louis, Mo.

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.