

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017995

FILED VS APR 25 1960

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 17

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>			Length of stay in 1b <b>6 days</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Marshall State School and Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>9021 Grand</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Terrance Edward Mallgren</b>				4. DATE OF DEATH Month Day Year <b>April 18, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-13-1945</b>	9. AGE (last birthday) <b>14</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patient</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Kenneth William Mallgren</b>			13b. MOTHER'S MAIDEN NAME <b>Virginia McIntyre</b>			14. NAME OF HUSBAND OR WIFE <b>----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records at Marshall State School &amp; Hosp. Marshall, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pulmonary tuberculosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Epileptic idiot.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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		COUNTY	STATE
21. I attended the deceased from <b>4-12-1960</b> to <b>4-18-1960</b> and last saw her/him alive on <b>4-18-1960</b> Death occurred at <b>11:00 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>A. B. Day</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>		22c. DATE SIGNED <b>4-19-60</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-19-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kansas City, Mo.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Harry Hershey</b>		ADDRESS <b>Marshall Mo</b>		25. DATE RECD. BY LOCAL REG. <b>4-19-60</b>		26. REGISTRAR'S SIGNATURE <b>Cecil G. Read</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harry Hershberg*

Licensed Embalmer No. 435

P. O. Address Marshall

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.