

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018450

FILED VS MAY 31 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 584

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Ruchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Doniphan					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 Weeks		c. CITY OR TOWN Wathena		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rural		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Thomas Middle Berman Last Malson				4. DATE OF DEATH Month May Day 16 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1908		9. AGE (last birthday) 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed			10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and state or country) Gentry County, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Thomas Malson			13b. MOTHER'S MAIDEN NAME Blanch Rucker			14. NAME OF HUSBAND OR WIFE unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. #2			16. SOCIAL SECURITY NO. 565-44-0340		17. INFORMANT Address Mrs. Bonnie Quinn, Whittier, California				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent meningitis + Ventriculitis							INTERVAL BETWEEN ONSET AND DEATH 5 weeks		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Postoperative complication after removal of spontaneous cerebellar hematoma							INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
DUE TO (c) of spontaneous cerebellar hematoma							INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary fibrosis + emphysema						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 8/4/59 to 5/16/60 and last saw ^{her} him alive on 5/16/60 Death occurred at 1:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Donald J. Stallard, MD				22b. ADDRESS 902 E. Imoud St			22c. DATE SIGNED 5/18/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE May 20, 1960		23c. NAME OF CEMETERY OR CREMATORY Hall Cemetery		23d. LOCATION (City, town, or county) Stanberry, Missouri			
24. FUNERAL DIRECTOR ADDRESS Beachcroft Funeral Home 1760			25. DATE RECD. BY LOCAL REG. May 25, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Garland				

DOCUMENT

By Stallard, Donald J. M.D. Medical Certification

BY AFFIDAVIT OF

0961 T 700

STATEMENT BY LICENSED EMBALMER

0961 T N00

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 *St. J. Phony*

Licensed Embalmer No. 467

P. O. Address St. Joseph

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.