

# VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-022425**  
STATE FILE NUMBER

FILED VS JUL 11 1960

042

726

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Twp</b> Length of stay in 1b _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>  c. CITY OR TOWN <b>St. Joseph</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>Lake Contrary</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1816 Clay St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>LAWRENCE</b> Middle <b>R.</b> Last <b>MALLORY</b>	<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>2,</b> Year <b>1960</b>
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<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12-13-1930</b>	<b>9. AGE</b> (last birthday) 29	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Mid Central Fish Co.</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Joseph, Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Lawrence P. Mallory</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Marie Ketchum</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Mary Louise Mallory</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <b>Korean</b>	<b>16. SOCIAL SECURITY NO.</b> <b>491-28-4702</b>	<b>17. INFORMANT</b> Address <b>Mrs L.R. Mallory St. Joseph, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> DUE TO (b) <b>accidental drowning</b> DUE TO (c) <b>Inability to swim</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>  <b>20 minutes</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>While wading, slipped into deep water</b>
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<b>20c. TIME OF INJURY</b> Hour <b>10:35</b> Month, Day, Year <b>July 2-60</b>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Sugar house</b>
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<b>21. I attended the deceased from</b> <b>craved body</b>	and last saw him <sup>alive</sup> on <b>July 3-60</b>
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Death occurred at **10:50 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>S.E. Melaney M.D. Coronor</b>	<b>22b. ADDRESS</b> <b>214 North Street St Joseph 8 Mo</b>	<b>22c. DATE SIGNED</b> <b>7-5-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial	<b>23b. DATE</b> <b>July 5, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Joseph, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>H.O. Sidenfaden &amp; Son</b>	ADDRESS <b>St Joseph, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>July 5, 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Mrs. Clark Goodell</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION  
S.E. Melaney M.D.

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 Robert H. Gypch

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.