

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048569

FII 12 VS DEC 1 9 1960

STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 6267 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <u>Webster</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Webster</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Elkland</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 Mi. N. E. of Elkland</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 1/2 mi. N. W. of Elkland</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>E. LEE</u> Last <u>MALLARD</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1960</u>	
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1868</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and state or country) <u>Dallas Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>D. Franklin mallard</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Carter</u>	14. NAME OF HUSBAND OR WIFE <u>George Mallard Elkland, Mo.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>George Mallard Elkland, Mo.</u>	Address <u> </u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy - Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>		?
	DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>	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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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.) <u> </u>
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from 1950 to 12-9-60 and last saw him alive on 12-8-60
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. O. Hamm</u> M.D.	22b. ADDRESS <u>Buffalo Mo.</u>	22c. DATE SIGNED <u>12-12-60</u>
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23a. CREATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Thorpe cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>L. B. Jones</u>	ADDRESS <u>Buffalo, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-18-60</u>	26. REGISTRAR'S SIGNATURE <u> </u>
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(Licensed Embalmer's Statement on Reverse Side)

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

R.E. Cheatham

Licensed Embalmer No. 3813

P. O. Address Buffalo, N.Y.

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.