

AMENDED FILED APR 24 1961 Primary Registration District No. Registrar's No.

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|---|--|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Marion | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in lb | | c. CITY OR TOWN Patoka | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Route 2 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROY IRA MALAN | | | 4. DATE OF DEATH Month Day Year APRIL 10 1961 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11/13/1889 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Highland, Ill. | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Levi Malan | | 13b. MOTHER'S MAIDEN NAME Mary Tremblay | | 14. NAME OF HUSBAND OR WIFE Maude | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Grover Malan, Odin, Ill. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY FAILURE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | STAPHYLOCOCCAL SEPSIS AND ACUTE PYELONEPHRITIS | | | | | 4 MONTHS |
| | DUE TO (c) | AMEGAKARYOCYTIC THROMBOCYTOPENIA, ETIOLOGY | | | | | 4 MONTHS |
| | DUE TO (c) | UNDETERMINED | | | | | 4 MONTHS |
| 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"/> N. <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 296x | | | |
| 20c. TIME OF INJURY Hour s.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 JAN. 12, 1961 to APRIL 10, 1961 and last saw her alive on APRIL 10, 1961 Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>E. J. Miller, M.D.</i> (Degree or title) | | | 22b. ADDRESS M. D. BARNES HOSPITAL | | | 22c. DATE SIGNED 4/11/61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4-13-61 | 23c. NAME OF CEMETERY OR CREMATORY Patoka Cemetery | | 23d. LOCATION (City, town, or county) Patoka, Ill. | | (State) | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | | | 25. DATE RECD. BY LOCAL REG. APR 11 1961 | | 26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i> | | |

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

BAVIERE HOSPITAL

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 Harvey Kahel

Licensed Embalmer No. 4596

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.