

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-61-024313**

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 182

FILED AUG 8 1961

1. PLACE OF DEATH a. COUNTY <u>Collaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Collaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>	Length of stay in lb <u>50 yrs.</u>	c. CITY OR TOWN <u>Fulton</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Collaway Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>318 W. 7th</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>G.</u> Last <u>Maland</u>			4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1886</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>plumbing</u>		11. BIRTHPLACE (City and state or country) <u>Hillmore, Courtn. Miss. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Martin Maland</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Ormrod</u>		14. NAME OF HUSBAND OR WIFE <u>Collie Hoffman</u>		
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>name</u>		17. INFORMANT <u>Mrs. J. G. Maland</u> Address <u>Fulton Mo.</u>	

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>cerebral hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>then arterio sclerosis</u>		
DUE TO (c) <u>Rf emphysema, atherosclerosis, degenerative heart disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (or that 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

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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		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 <u>Fulton</u> COUNTY <u>Missouri</u> STATE <u>Mo.</u>	

21. I attended the deceased from July 30, 61 to July 31, 61 and last saw her alive on July 30-61  
Death occurred at 1:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. Lawrence M.D.</u>		22b. ADDRESS <u>Fulton Mo.</u>		22c. DATE SIGNED <u>8/2/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>8/1/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	
24. FUNERAL DIRECTOR <u>Glen U. Mathin</u>		ADDRESS <u>Fulton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 2-1961</u>	
26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>					

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1961 AUG 9 SA

1961 AUG 9 SA

**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 Thomas M. Emmon

Licensed Embalmer No. 5064

P. O. Address Fulton, 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.