

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037345

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 216

FILED OCT 8 1962

VS 300
Rev. 4/59

1 1007
2 1007
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4 0
5 1
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7 1
8 0
9 4200
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12 1-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Sikeston</u>	
Length of stay in 1b		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>Mo. Delta Community</u>		d. STREET ADDRESS (If outside, give location) <u>717 Ruth</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Early John Malcolm</u>			4. DATE OF DEATH Month Day Year <u>September 29 1962</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>5-20-1896</u>
9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. ST HIGHWAY DEPT</u>	11. BIRTHPLACE (City and state or country) <u>PARIS TENN</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>DR. P. M. MALCOLM</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA JANE PERRY</u>	
14. NAME OF HUSBAND OR WIFE <u>HAZEL</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.	
17. INFORMANT <u>Hazel Malcolm - Sikeston Mo</u>		Address	
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>Pulmonary Edema</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema, Bronchial Asthma, A5HD</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
19. WAS AUTOPSY PERFORMED? YES <input 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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 <u>Sept. 25 '62</u> to <u>Sept. 29, '62</u> and last saw <u>her</u> alive on <u>Sept. 29, '62</u> Death occurred at <u>3:58 P. m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Thomas (Maltrip) MD</u>		22b. ADDRESS <u>Sikeston, Mo.</u>	
22c. DATE SIGNED <u>10-3-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-1-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>City</u>		23d. LOCATION (City, town, or county) (State) <u>SIKESTON Mo</u>	
24. FUNERAL DIRECTOR <u>Welsh Funeral Home - Sikeston Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 3 - 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>			

USE BLACK INK OR TYPEWRITER RIBBON

APR 16 1963

Permit renewed Sept 29, 1962

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sebastian 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.