-7631

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30539

OCT 1 - 1939

Registration District No. 701 Primary Registration District No. Registrar's No. 7602

1. PLACE OF DEATH: 1003 1

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 1

(c) City or town ST. LOUIS 26
(If outside city or town limits, write "RURAL")

(d) Street No. 2223 A. N. 10TH STR.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Malone 450

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased APRIL 20TH 1939 (Month) (Day) (Year)

8. AGE: Years | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace ST. LOUIS MO. (City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business

FATHER 12. Name WALTER MALONE

13. Birthplace ST LOUIS MO (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name LORETTA GODNISH

15. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter Malone

(b) Address 2223 A N 10th St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEP. 2 1939 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Brockland UND. CO

(b) Address 1827 HOGAN STR

19. (a) SEP 2 1939 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 1, year 1939 hour 1:20 minute P. M.

21. I hereby certify that I attended the deceased from August 29, 1939, to September 1, 1939; that I last saw him alive on September 1, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Diarrhea — Duration 3 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. E. Shukleovski (Coroner)

Address City Hospital, #1, St. Louis

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 1-1-39 I X18511

No Embalming

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.