

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940 801

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41954
Registrar's No. 11077

Registration District No. 1003 Primary Registration District No.

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution 1 mo 23 days
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Mable Malone
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col 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 July 24th 1899
(Month) (Day) (Year)

8. AGE: Years 40 Months 4 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace Atlanta Ga
(City, town, or county) (State or foreign country)

10. Usual occupation housework

11. Industry or business _____

MOTHER FATHER { 12. Name Jack Malone
18. Birthplace Bondville Ga
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Keath
15. Birthplace Macon Ga
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. Ireland
(b) Address 2940a Lucas Ave

17. (a) Burial (b) Date thereof 12/27/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle & Son
(b) Address 3133 Bell Avenue

19. (a) DEC 27 1939 (b) J. B. Braddock
(Date and local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2940 a Lucas
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 22nd
year 1939 hour 9:00 minute 50 A. M.
21. I hereby certify that I attended the deceased from October 30, 1939, to December 22, 1939,
that I last saw her alive on December 22, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix c Metastasis Duration 1 yr
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy Carcinoma of Cervix c Metastasis

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. AmcDowee (M. D. or other) _____
Address 2601 N Whittier Date signed _____

12/27/39

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.....

S J Watson

Licensed Embalmer No.....

2698

P. O. Address.....

2769 Courtland

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.