

**AUG 25 1940**

Registration District No.

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (c) Name of hospital or institution: Homer G. Phillips  
 (If not in hospital or institution, write street number or location) 1  
 (d) Length of stay: In hospital or institution 15 days (Specify whether  
 In this community 41 years years, months or days)

3. (a) PRINT FULL NAME Callie Mae Malone 450

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. Unk

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Walter Malbae 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased June 6, 1895  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 0 13 hr. min.

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

10. Usual occupation Unk

11. Industry or business Unk

12. Name Benton Hutt

13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

14. Maiden name Birdie Sneathern

15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Florence A. Spotts

(b) Address Homer G Phillips Hospital

17. (a) Burial (b) Date thereof 7/25/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director J. Hamilton

(b) Address City Health Dept.

19. (a) JUL 24 1940 (b) J. F. Prudick  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 21  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 622 N. Beaumont  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19  
 year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6-4- 1940, to 6-19- 1940.

that I last saw her alive on 6-19- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, Esophagus About 2 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy As above

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 G. A. Mc Dowell (M. D. or other) 8-21-1940

Address 2601 N. Whittier Date signed \_\_\_\_\_

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

Rev. 8-17-39  
 Form 1 X1931

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.

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**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.**