

Registration District No. 391

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Robert Malone Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days (Specify whether  
In this community 12 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1108 Tracy (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME ROBERT MALONE

3. (b) If veteran, name war No 3. (c) Social Security No. 487-05-9734

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida Mae Malone 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased July 14 1911  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
30 5 11 hr. \_\_\_\_\_ min.

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

10. Usual occupation Baker

11. Industry or business None

12. Name Herbert Malone

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

14. Maiden name Ida Mae

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

16. (a) Informant Mrs. Ida Mae Malone, (Wife)

(b) Address 1108 Tracy, K.C. Missouri

17. (a) Burial (b) Date thereof 12-27-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill, K.C. Mo.

18. (a) Signature of funeral director Walter Farnum Hanna

(b) Address 2011 1/2 Olive St., K.C. Mo.

19. (a) 12/27/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25th  
year 1941 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from 12-15-41, 19\_\_\_\_, to 12-25-41, 19\_\_\_\_; that I last saw him alive on 12-25-41, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis  
Due to Ruptured appendix

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy None

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 Dr. W. L. Thoms (M. D. or other)  
Address Med. Dir. K.C. General Hospital Date signed \_\_\_\_\_

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

MOTHER FATHER

048  
3  
8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

12111

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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

*Jimmy S. Huckshorn*

Licensed Embalmer No. *4092*

P. O. Address *N.C. Kause*

**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, fact should be so stated above.**