

No. 2
A-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33323

State File No. _____

NOV 10 1943

318

1003

Registrar's No. 9486

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(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: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community Undet. (Specify whether
years, months or days)

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

4. Sex Female 5. Color or race Colored 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 Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt 55 Unknown _____ hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER { 12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley Smith
(b) Address 2601 Whittier

17. (a) Place: burial or cremation Washington
(b) Date thereof 10-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director W. R. ...
(b) Address 2601 Whittier St.

19. (a) OCT 28 1943 (Date received local registrar) J. F. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1721
(c) City or town St. Louis, 9
(If outside city or town limits, write "RURAL")
(d) Street No. 3437 Lawton (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12,
year 1943 hour 4 minute 20 A. M.
21. I hereby certify that I attended the deceased from October
5, 19 43 to October 12, 19 43
that I last saw her alive on October 12, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration Unk.

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature S. E. Smith (M. D. or other) 10/14/43
Address 2601 Whittier Date signed _____

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

9486

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, fact should be so stated above.