. S. No. 2
0M—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36041

FILED NOV 3 1947 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 9626

1. PLACE OF DEATH:

(a) County

(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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 095

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2715 Cass Ave. 9
(If rural, give location)

20 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wilson Malone

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2 Color or race Negro

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 12 (Month) 10 (Day) 1938 (Year)

8. AGE: Years 8 Months 10 Days 6 If less than one day hr. — min.

9. Birthplace St Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation —

11. Industry or business

MOTHER FATHER

12. Name Robert Beatrice Malone 0

13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

14. Maiden name Beatrice Moody

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

16. (a) Informant Earl Moody

(b) Address 2715 S Cass ave

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

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Jackson Funeral Home

(b) Address 2649-51 Delmar Blvd

19. (a) OCT 20 1947 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16 year 1947 hour 6 minute 20 A. M.

21. I hereby certify that I attended the deceased from Oct. 14 1947 to Oct. 16 1947 that I last saw him alive on Oct. 16 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Perforated Appendicitis and	Undet.
Generalized Peritonitis	
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy None

PHYSICIAN

Underline the cause of 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 (Means of injury) 0

23. Signature Theodore Blevins (M. D. or other)

Address 2601 N Whittier St Date signed 10/17/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Embalmers separate cert. to be filed OCT 20 1947

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.