S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 22 1947 618

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39939

Registrar's No. 10370

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community

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. 2618 Stoddard
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frank Malone
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
4. Sex Male
5. Color or race C
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Katie Malone
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased March 16 (Month) 1870 (Year) (Day)

8. AGE: Years 77 Months 7 Days 20 If less than one day hr. min.

9. Birthplace Cape Girardeau (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business --
MOTHER FATHER
12. Name Unavailable
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Katie Malone
(b) Address 2618 Stoddard St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Av.
19. (a) NOV 10 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5 year 1947 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Nov. 3, 1947, to Nov. 5, 1947 that I last saw him alive on Nov. 5, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration Undet.
Hypertensive Heart Disease — "
Due to
Due to
Other conditions Left Hemiplegia
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

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? (e) Means of injury

23. Signature Oscar J. Daniel (M. D. or other)
Address 2601 No Whittier Date signed 11/6/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 John K. Cunningham, Registered Apprentice No. 452, working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.