

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40247**
Registrar's No. **5071**

Registration District No. **149**

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;
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day 5 hrs.**
(Specify whether years, months or days) **40 yrs.**

3: (a) PRINT FULL NAME **Fred Malone**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Maudie F. Malone** 6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Dec-12-1878**
(Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **28** If less than one day **27** hr. min.

9. Birthplace **N. York**
(City, town, or county) (State or foreign country)

10. Usual occupation **Steamy Litter**

11. Industry or business **Retires**

12. Name **Peter B. Malone**

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

14. Maiden name **Rose Davis**

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

16. (a) Informant **Maudie F. Malone**

(b) Address **613 E. 16 St.**

17. (a) **Burial** (b) Date thereof **Dec 14-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Thos. C. Foster**

(b) Address **918 Broadway**

19. (a) **12-13-48** (b) **Staldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
Kansas City
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **613 E. 16 St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **9**
year **1948** hour **11** minute **5 P.** M.

21. I hereby certify that I attended the deceased from **Dec. 8**, 19**48**, to **Dec. 9**, 19**48**
that I last saw him alive on **Dec. 9**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral thrombosis**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **83B**

Of autopsy **See above**

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?

Wm. W. Hart (Specify type of place) While at work? (e) Means of injury

23. Signature **Wm. W. Hart** (M. D. or other) **12-10-48**
Address **Med. Dir. Gen'l Hosp.** Date signed

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

MOTHER, FATHER

Am...

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 Joe B. Yoder
Licensed Embalmer No. 4173
P. O. Address NC Mo

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.