

No. 2  
4-13-40  
5-17-39  
D X23159

NOV 16 1940  
FIVE

791

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town. St. Louis.  
(c) Name of hospital or institution:  
3855 Page Blvd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether  
In this community. 50 Years.  
years, months or days)

3. (a) PRINT FULL NAME Joseph A. Mallon.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 486-16-8754

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

6. (b) Name of husband or wife. Delia Mallon. 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased. October 5, 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>0</u>	<u>16</u>	hr. _____ min.

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

10. Usual occupation Works Progress Administration

11. Industry or business \_\_\_\_\_

12. Name Patrick Mallon.

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

14. Maiden name Rose Bradley.  
15. Birthplace Ireland.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Delia Mallon.

(b) Address 3855 Page Blvd.

17. (a) Burial (b) Date thereof 10-24-40  
(Burial, cremation, or removal) (Month, Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) OCT 23 1940 (b) \_\_\_\_\_  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo. (b) County \_\_\_\_\_  
(c) City or town. St. Louis. 11  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3855 Page Blvd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21st.  
year 1940 hour 1:00 minute. P. M.

21. I hereby certify that I attended the deceased from March, 1940, to Oct. 21, 1940  
that I last saw him alive on Oct. 20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death. Bronchogenic Carcinoma Lung (left upper lobe)  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
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) no  
(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 John Hammond (M. D. or other) M.D.  
Address 634 N Grand Date signed 10/21/40

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

MOTHER FATHER

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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

*W. Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

**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.**