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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 23 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1332

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

**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: MISSOUR PACIFIC HOSPITAL O
(If not in hospital or institution, write street number or location)

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI, (b) County

(c) City or town ST. LOUIS 1400
(If outside city or town limits, write "RURAL")

(d) Street No. 5317 DELOR ST. 19
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 9

If yes, name country O

3. (a) PRINT FULL NAME James Colus Mallon

3. (b) If veteran, name war NO

3. (c) Social Security No. 702-16-9620

4. Sex MALE O

5. Color or race WHITE

6. (a) ~~Single~~, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ISABELLA MALLON

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased FEBRUARY 7 1883
(Month) (Day) (Year)

8. AGE: Years 60 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace ST. LOUIS MO O
(City, town, or county) (State or foreign country)

10. Usual occupation OFFICE CLERK

11. Industry or business MISSOURI PACIFIC R.R.

FATHER
12. Name JAMES MALLON
13. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY UNKNOWN
15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Isabella Mallon
(b) Address 5317 Delor St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 11 1943
(Month) (Day) (Year)
(c) Place: burial or cremation SUNSET BURIAL PK.

18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette av

19. (a) FEB 9 1943 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)
FEB 10 1943

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 9
year 1943 hour 2 minute 30 a M.

21. I hereby certify that I attended the deceased from 1-28, 1943, to 2-9, 1943;
that I last saw him alive on 2-8, 1943;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Recurrent bronchiogenic carcinoma of neck (neck) | |
| Due to | |
| Due to 55 | |
| 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Heinz S. Cron O (M. D. ~~or other~~)
Address Mo Pacific Hospital Date signed 2/9/43

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Av.

**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.**