

FILED JUL 24 1944
Registration District No. **197**

Primary Registration District No. **1002**

Registrar's No. **2854**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 Weeks.** **0**
(Specify whether)
 In this community **9 Years.**
years, months or days

3. (a) PRINT FULL NAME **Margaret T. MALLOT.**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mat. L. Mallot**
 6. (c) Age of husband or wife if alive **60** years
 7. Birth date of deceased **August 24th, 1884**
(Month) (Day) (Year)

8. AGE: Years **59** Months **10** Days **15**
 If less than one day **hr. min.**

9. Birthplace: **Lexington Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation: **House Wife**

11. Industry or business:
12. Name: **Michael McDonald**
13. Birthplace: **Unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name: **Margaret Gavin**
15. Birthplace: **Missouri** **0**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mat. L. Mallot.**
(b) Address: **3316 East 24th, Street.**
17. (a) Removal: **Removal** **(b) Date thereof:** **7/9/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Lexington Missouri**
18. (a) Signature of funeral director: **Melody-McGilley**
(b) Address: **K. C. Mo.**
19. (a) 7-10-44 (b) T. C. Brown (N3)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **48**
 (c) City or town **Kansas City Mo.** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3316 East 24th, Street**
(If rural, give location)
 (e) Citizen of foreign country? **No.** **0** (Yes or No)
 If yes, name country **0**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **9th**
 year **1944** hour **6** minute **A. M.**
21. I hereby certify that I attended the deceased from **1939** to **July 9, 1944**
 that I last saw her alive on **July 8, 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **pneumonia lobar**
 Due to **acute fibrinous Pericarditis**
 Due to **Myocardial failure**
 Other conditions **108**
(Include pregnancy within 3 months of death)
 Major findings: **108**
 Of operations
 Of autopsy **above described**

Duration
 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?
 While at work? (Specify type of place) (e) Means of injury
23. Signature: **Elizabeth Seston** (M. D. or other)
 Address: **3023 W. 11th St.** Date signed: **7-10**

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

MOTHER FATHER

Dr. Gestling

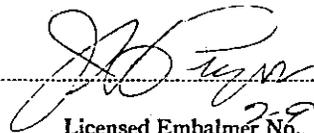
STATEMENT BY LICENSED EMBALMER

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. 2999.....

P. O. Address..... K.C.

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.