

FILED JAN 27 1946

Registration District No. **31** Primary Registration District No. **6076**

Registrar's No. **11**

1. PLACE OF DEATH:
(a) County **St Louis**
(b) City or town **Normandy**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Sullivan Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St Louis 96**
(c) City or town **Normandy**
(If outside city or town limits, write "RURAL")
(d) Street No. **O'Sullivan Nursing Home**
(If rural, give location) **N.P.**
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country

3. (a) PRINT FULL NAME **William Mallon**
3. (b) If veteran, name war No. 3. (c) Social Security No.

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single 0**
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased **August 9, 1882**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	4	26	hr. min.

9. Birthplace **Missouri 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business

MOTHER FATHER {
12. Name **John Mallon**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Lusk**
15. Birthplace **Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jennie Crowder**
(b) Address **1212a S. Boyle**
17. (a) **Removal** (b) Date thereof **1/6/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Salem, Mo.**

18. (a) Signature of funeral director **Edith E. Ambruster**
(b) Address **4234 Manchester**
19. (a) **JAN 5 1946** (b) **E. H. Mc Davran, MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **5**
year **1946** hour **6** minute **30 A.M.**
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Congestion } myocardial failure** Duration
Severe arteriosclerosis: -

Due to _____
Due to **97**

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?

While at work? (Specify type of place) _____ (e) Means of injury _____
23. Signature **Deen Salans** (M. D. or other) **MD**
Address **7320 Plummer Rd** Date signed **1/17/46**

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

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.....

Henry Eynck

Licensed Embalmer No. *1284*

P.,O. Address. *St. Louis, 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.

Registration District No. *317*

Primary Registration District No. *6076*

Registrar's No. *1*

1. PLACE OF DEATH:

(a) County *St Louis*
(b) City or town *Normandy*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME *William Mallon*

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

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *s*

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive.

7. Birth date of deceased *aug 9 1913*
(Month) (Day) (Year)

8. AGE: Years *63* Months *6* Days *6* If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

(b) Address

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address

19. (a) *1-5-46* (Date received local registrar) (b) *BB McFarland MD* (Registrar's signature) *msc*

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

20. DATE OF DEATH: Month *Feb* Day *19* Year *1946* (hour) (minute) M.

21. I hereby certify that I attended the deceased from *10* to *11* 19*46*; that I last saw him *alive* on *19* and that death occurred on the date and hour stated above. Immediate cause of death.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

MEDICAL CERTIFICATION

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2168

2D
45
3880

4074