

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35092

State File No.

318

1003

8670

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis	c. LENGTH OF STAY (in this place) 2 1/2 Yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis	2229
d. FULL NAME OF HOSPITAL OR INSTITUTION InRoute Homer G. Phillips Hospital 22		d. STREET ADDRESS (If rural, give location) 1015, California	
3. NAME OF DECEASED (Type or Print) a. (First) Freddie b. (Middle) Adolphia c. (Last) Malone		4. DATE OF DEATH (Month) (Day) (Year) 10- 11th 1950	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 3-10th 1909
9. AGE (in years last birthday) 41	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Hours 1	11. BIRTHPLACE (State or foreign country) Holly Springs Mississippi
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Henry Malone	
13b. MOTHER'S MAIDEN NAME Sarrah Godlock		14. NAME OF HUSBAND OR WIFE Sadie Malone Smith	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Matilda Wilson	
		ADDRESS 310, A. South Ewing	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Compound fracture of skull. Laceration of brain, suffered when car operated by one Roosevelt Hope (Col.) in which deceased was a passenger struck light standard and building in front of about 3805 Market Street, around 12:50 A.M., Oct. 11th, 1950. ACCIDENT.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 000	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUBJECT HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY), (STATE) St. Louis, Mo, 64194
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) 6:31	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? See above

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE Joseph M. ...	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10/13/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-23-50	24c. NAME OF CEMETERY OR CREMATORY Holly Springs	24d. LOCATION (City, town, or county) (State) Mississippi
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DATE REC'D BY LOCAL REG. OCT 13 1950	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE John H. Houston	ADDRESS 2829 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

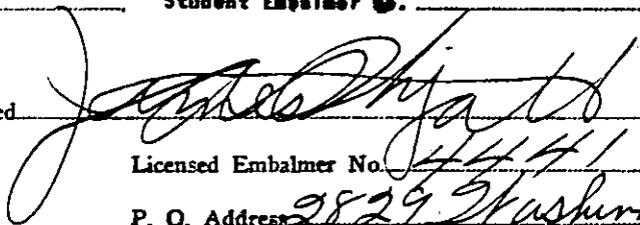
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. 4441

P. O. Address 2829 Washington

**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.