

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **36631**
9591

NOV 12 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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 town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pac. Hospital		d. STREET ADDRESS (If rural, give location) 2815a Dickson Street	

3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) c. (Last) Malone			4. DATE OF DEATH (Month) (Day) (Year) 10 15 52			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-18-'87		9. AGE (In years last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Porter		10b. KIND OF BUSINESS OR INDUSTRY RR		11. BIRTHPLACE (City and State or Foreign Country) Greenville, Miss.		
12. CITIZEN OF WHAT COUNTRY? USA						

13a. FATHER'S NAME John Malone	13b. MOTHER'S MAIDEN NAME Belle Brown	14. NAME OF HUSBAND OR WIFE Laura Malone
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WORLD WAR #1	17. INFORMANT'S SIGNATURE OR NAME Laura Malone	ADDRESS 2815a Dickson St.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 11 days
	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. Idiopathic effusion in left Pleural Cavity		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 491X

22. I hereby certify that I attended the deceased from **Oct 6, 1952, to Oct 15, 1952**, that I last saw the deceased alive on **Oct 15, 1952**, and that death occurred at **10:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE J. Louis Schuchat MD (Degree or title)	23b. ADDRESS 3566 Flora Place	23c. DATE SIGNED Oct 17 52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-18-52	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Greenville, Miss.
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DATE REC'D BY LOCAL REG. OCT 18 1952	REGISTRAR'S SIGNATURE E. Earl Smith md	25. FUNERAL DIRECTOR'S SIGNATURE Russell Und., Co.	ADDRESS 2732 Pine Blvd.
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Not Licensed Embalmer's Statement on Reverse Side

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 No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

James A Carter

Licensed Embalmer No. *4681*

P. O. Address *St Louis*

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.