

Registration District No. 791 Primary Registration District No. 1003

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:
City Sanitarium
(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)

3. (a) PRINT FULL NAME Malinda E Dewey

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife John Dewey 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 3rd 1855
(Month) (Day) (Year)

8. AGE: Years 84 Months 10 Days 18 If less than one day
hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown Matlock
13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Dewey
(b) Address 4531a Labadie Ave
17. (a) Burial (b) Date thereof 10/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton At Concordia Lane

19. OCT 22 1940 (b) J. F. Bruch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. City Sanitarium 13
(If rural, give location) -
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21st
year 1940 hour 6 minute _____ P. 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 Chronic Interstitial Myocarditis; Contrib: Chronic Interstitial Nephritis; Arterio-Sclerosis;

Due to _____

Due to _____

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) (a) Months of injury _____
23. Signature Charles Perry (M. D. or other) _____
Address City Sanitarium Date signed 10/22/40

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. #1994

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.