

1. PLACE OF DEATH:

(a) County St Louis, Mo
(b) City or town St Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
In this community 16 days
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1941 hour 5 minute 30 A. M.
21. I hereby certify that I attended the deceased from October 14
1941, to October 30 1941.
that I last saw her alive on October 30 1941.
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism Duration 24 hrs
Due to Extensive metastases 6 mos
Due to Cancer of uterus 1 yr
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Ca of uterus
Of autopsy Ca of corpus uteri - metastases to liver & lungs
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)

3. (a) PRINT FULL NAME Jane Tina Mallinckrodt
3. (b) If veteran, name war No
3. (c) Social Security No. NONE

4. Sex F 5. Color or race white 6. (a) Single, widowed, divorced, married
(b) Name of husband or wife Ewald Mallinckrodt (c) Age of husband or wife if alive 27 years
7. Birth date of deceased Nov. 27 1889
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 3
If less than one day hr. min.

9. Birthplace Lexington, Lafayette Co, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business

MOTHER FATHER { 12. Name Joseph Perry
13. Birthplace Lexington, O Mo
(City, town, or county) (State or foreign country)
14. Maiden name Sarah E. ?
15. Birthplace Lexington, O Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Ewald Mallinckrodt
(b) Address Farmington, Mo

17. (a) REMOVAL (b) Date thereof 10-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation FARMINGTON, Mo

18. (a) Signature of funeral director Albert H. Hugg
(b) Address 4470 Washington Blvd

19. (a) OCT 30 1941 (b) J F Brubaker
(Date received local registrar) (Registrar's signature)

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

MAR 19 1958

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

Walter T. Beersley
Licensed Embalmer No. 4202

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. _____

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: _____
(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)

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 _____

3. (a) PRINT FULL NAME **Jane T. Malinekott**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year **1941** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **unknown** years
7. Birth date of deceased **Nov 27 1889**
(Month) (Day) (Year)

8. AGE: Years **52** Months **11** Days **11** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **DEC 5 1941** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

Duration _____
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 _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

P0-0500