

Registration District No. **818**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1399 Clara ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 23 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna Malley

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

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Nathan Malley 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years about 71 Months Days If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name Nathan Leeger

13. Birthplace Poland (City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace Poland (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marie Becker

(b) Address 1399 Clara

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12/13/43 (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson ave.

19. (a) DEC 13 1943 (Date received local registrar) (b) J. P. Brudwick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1399 Clara ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8 year 43 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1 1943 to Dec 8 1943 that I last saw him alive on Dec 8 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Crown thrombosis Duration 12 hours

Due to arterio sclerosis general many years

Other conditions non (Include pregnancy within 3 months of death)

Major findings: Of operations non

Of autopsy non

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 _____

Signature Joseph M. ... (M. D. or other) non
Address 1510 West 9th Date signed 12-14-43

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

MOTHER FATHER

848

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. 1577

P. O. Address.....

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.