

FILED JAN 16 1945 18

State File No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 20

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:  
4864 1/2 TENROSE STR.  
(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 Mo (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4864 1/2 TENROSE STR.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME RUTH ELIZABETH MALLON

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 SINGLE  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased SEPT. 10<sup>th</sup> 1902  
(Month) (Day) (Year)

8. AGE: Years 42 Months 3 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation STENOGRAPHER

11. Industry or business MO. BREWERS ASSOCIATION

12. Name JAMES H. MALLON

13. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name SOPHIE BREUGEMAN

15. Birthplace Mo (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Mrs Sophie Mallon

(b) Address 4864 1/2 Penrose Str.

17. (a) BURIAL (b) Date thereof. JAN. 4-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director J. F. Bredeck

(b) Address 516 S DELMAR BLVD

19. (a) JAN 3 1945 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 1<sup>st</sup>  
 year 1945 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8-15-1944  
 \_\_\_\_\_, 19\_\_\_\_, to Jan. 1, 1945

that I last saw h. u alive on 12-30-1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Submaxillary metastases

Due to carcinoma of cervix and uterus

Due to Primary in cervix

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)  
 (c) Means of injury \_\_\_\_\_

23. Signature: J. F. Bredeck (M.D. or other) (M.D.)

Address 4155 N. Newstead Date signed 1-2-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 *N. G. Farris*

Licensed Embalmer No. *3384*

P. O. Address *St. Louis*

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

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