

FILED AUG 11 1945 STANDARD CERTIFICATE OF DEATH

State File No. 22265
Registrar's No. 6884

Registration District No. 318 Primary Registration District No. 100

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(c) Name of hospital or institution City Isolation Hospital
(d) Length of stay: In hospital or institution 1-3-1945 to 7-30-1945

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(d) Street No. 5800 Arsenal Street
(e) Citizen of foreign country? 0 (Yes or No)

3. (a) PRINT FULL NAME August Malen
(b) If veteran, name war
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 30 year 1945 hour 11 minute A.M.

4. Sex Male 0
5. Color or race White
6. (b) Name of husband or wife
7. Birth date of deceased 11/13/1869

21. I hereby certify that I attended the deceased from Jan. 31, 1945 to July 30, 1945; that I last saw him alive on July 30, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of pylorus

8. AGE: Years 76 Months 8 Days 17

Due to Metastatic carcinoma of upper bowel

9. Birthplace Lithuania

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

10. Usual occupation

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business

MOTHER FATHER { 12. Name John Malen
13. Birthplace Lithuania
14. Maiden name
15. Birthplace

16. (a) Informant Edith V. Minor
(b) Address 5600 Arsenal Street

17. (a) BURIAL (b) Date thereof 8-6-45
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director
(b) AUG 5 1945

19. (a) Date received local registrar
(b) J. F. Bradack (Registrar's signature)

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?
(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 [Signature] (M. D. or other)
Address 5800 Arsenal Street Date signed 7-30-1945

WRITE PLAINLY—USE 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

James A. Lammers

Licensed Embalmer No. *1A124842*

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.

Aug 23 1945

Registration District No. 318

Primary Registration District No. 1003

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

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:
(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

August malen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased mw 18 18 18
(Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace None Lithuania
(City, town, or county) (State or foreign country)

10. Usual occupation: None

11. Industry or business: None

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) AUG 27 1945 (b) J. F. Brudek
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

1945

S-22265