S. No. 2
M—2-43
7. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1945 318

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 29226

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8492

**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: BARNES Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 39 days (Specify whether years, months or days)

In this community _____

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Oklahoma (b) County Muskogee 999

(c) City or town Muskogee 34
(If outside city or town limits, write "RURAL")

(d) Street No. NK 0
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME Arahvilla Jane Malone

3. (b) If veteran, name war No.

3. (c) Social Security No. Unk.

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 June 6, 1924 (Month) (Day) (Year)

8. AGE: Years 21 Months 3 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Gov't. Clerk

11. Industry or business _____

MOTHER FATHER

12. Name Louis Malone

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

14. Maiden name Arahvilla Stevens

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

16. (a) Informant Louis Malone

(b) Address 305 Jefferson, Muskogee, Okla.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Muskogee, Okla.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 1 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 30 year 1945 hour 2 minute 50 A.M.

21. I hereby certify that I attended the deceased from Aug. 22, 1945, 19____, to Sept. 30, 1945; that I last saw her alive on Sept. 30, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Malignant teratoma of ovary

~~Due to~~ generalized metastasis

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature F. R. Bradley (M. D. ~~or other~~)

Address Barnes Hospital, Date signed 9/30

(Licensed Embalmer's Statement on Reverse Side)

## 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 Ry W Wilkinson

Licensed Embalmer No. 3575

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.**