

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15580

State File No. ....

FILED APR 23 1953

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3740**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>16 days</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2169</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Lukes Hospital</b>			d. STREET ADDRESS (If rural, give location) <b>16 3719 Giles Ave.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Anna</b>		b. (Middle) <b>May</b>	c. (Last) <b>Malick</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 7 1953</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>April 30, 1908</b>	9. AGE (In years last birthday) <b>44</b>	# UNDER 1 YEAR Months
# UNDER 1 YEAR Days	# UNDER 2 HRS. Hours	# UNDER 2 HRS. Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>
11. BIRTHPLACE (City and State or Foreign Country) <b>Centralia, Ill.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John W. Malick</b>		13b. MOTHER'S MAIDEN NAME <b>Augusta Mae Smith</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-01-3445</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>John Mallick 3653 Phillips Pl.,</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of ovary with generalized metastases</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY! YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>175X</b>		
22. I hereby certify that I attended the deceased from <b>Mar. 10, 1953</b> , to <b>April 7, 1953</b> , that I last saw the deceased alive on <b>April 7, 1953</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Name of Informant) <b>Geo. W. Allen</b>		23b. ADDRESS <b>3720 Washington Blvd</b>		23c. DATE SIGNED <b>4-9-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4/11/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Lemay, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>APR 9 1953</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister Colonial Mortuary 646 Chippewa St., St. Louis, Mo.</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Harold Newman  
Beaumont Bldg.,  
JE 4515

153  
3720 Washington

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Lina E. Hoffmeister*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.