

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43821**Registrar's No. **11157**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11157			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St Louis 4830		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION. St Anthony				e. STREET ADDRESS (If rural, give location) 4127 Burnett					
3. NAME OF DECEASED (Type or Print) a. (First) ISABELLE b. (Middle) R c. (Last) MALLON			4. DATE OF DEATH (Month) (Day) (Year) Dec 6 1954						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH June 16 1883		9. AGE (In years last birthday) 71	# UNDER 1 YEAR Months _____	# UNDER 1 YEAR Days _____	# UNDER 1 YEAR Hours _____	# UNDER 1 YEAR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? U			
13a. FATHER'S NAME John May			13b. MOTHER'S MAIDEN NAME Agnes Kirkwood		14. NAME OF HUSBAND OR WIFE James C Mallon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes Groepper 5543 Grace					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 153X					
22. I hereby certify that I attended the deceased from 9/16 , 19 52 , to 12/6 , 19 54 , that I last saw the deceased alive on 12/6 , 19 54 , and that death occurred at 12:40P m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Roy C. Ruppert M.D.				23b. ADDRESS 7702 Ivory Ln		23c. DATE SIGNED 12/7/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec 9 54	24c. NAME OF CEMETERY OR CREMATORY Sun Set Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo				
DATE REC'D BY LOCAL REG. DEC 7 1954		REGISTRAR'S SIGNATURE Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

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.....
Signature of Student Embalmer

Signed *Thomas R. Fenwick*.....

Licensed Embalmer No. *379*.....

P. O. Address *3125 Lafayette*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.