

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21991

State File No.

FILED JUN 25 1956

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5750

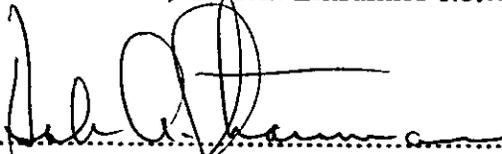
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital		e. STREET ADDRESS (If rural, give location) 4221 Shenandoah Str. 21991			
3. NAME OF DECEASED (Type or Print) a. (First) VEVIE		b. (Middle) P.		c. (Last) MALLM	
4. DATE OF DEATH June 15, 1956		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH Nov. 8, 1880		9. AGE (In years last birthday) 75	
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) Andover, Illinois.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Alfred Anderson		13b. MOTHER'S MAIDEN NAME Pernelia Bergland	
14. NAME OF HUSBAND OR WIFE Late Gustave Mallm		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Robert A. Mallm-1506 Jonquil Dr. W.G.		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.		19. INTERVAL BETWEEN ONSET AND DEATH 1 year.	
MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchogenic Carcinoma</u>		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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 162x		20. AUTOPSY? <u>Refused</u> 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-14</u> 19 <u>55</u> , to <u>6-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-14</u> , 19 <u>56</u> , and that death occurred at <u>11:40A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Eugene T. Dreyfus, MD</u>		23b. ADDRESS <u>University Club Bldg</u>		23c. DATE SIGNED <u>6-16-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal (Rail)</u>		24b. DATE <u>6-18-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Andover, Ill.</u>	
24d. LOCATION (City, town, or county) (State) <u>Andover, Ill.</u>		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser-4228 S.Kingshighway Bk.</u>	

WRITE PLAINLY—USING 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 Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 453

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