

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027212

STATE FILE NUMBER

FILED-JUL 18 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6823

S. 300  
-1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>267 3852<sup>nd</sup> UTAH</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH S. MALECEK SR.</u>			4. DATE OF DEATH Month Day Year <u>JULY 6 1958</u>		
5. SEX <u>MALE<sup>o</sup></u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 8 1885</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED COMPTROLLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.D. GEORGE PAINT CO. Mo.</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>STEPHEN MALECEK</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA BROZ</u>		14. NAME OF HUSBAND OR WIFE <u>ELEANORE MALECEK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>3852<sup>nd</sup> UTAH PL.</u> <u>ELEANORE MALECEK</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic acidosis (uremia)</u> <u>Diabetes mellitus</u> 260+					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Left renal neoplasm</u>					
DUE TO (c) <u>Left renal neoplasm</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 25</u> to <u>July 7</u> and last saw her/him alive on <u>July 6</u> Death occurred at <u>10 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>E. Russell M.D.</u>			22b. ADDRESS <u>3920 Washington</u>		22c. DATE SIGNED <u>7-8-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JULY 9 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter &amp; Paul</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUNERAL DIRECTOR <u>Thomas Kuter 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>JUL 8 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u> <u>m 8 B.</u>

11-1-2-3  
P. O. v. P. O.

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 *James C. Hill*

Licensed Embalmer No. *4342*  
P. O. Address *2906 Iowa*

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.