

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041932

STATE FILE NUMBER

318

1003

10527

FILED NOV 20 1958

Registration District No.

Primary Registration District No.

Registration District No.

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		c. CITY OR TOWN <b>Saint Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5370 Claxton Ave.</b>		d. STREET ADDRESS (If outside, give location) <b>5370 Claxton Ave.</b>	
Length of stay in lb <b>Life</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Selma M. Malone</b>			4. DATE OF DEATH Month Day Year <b>Nov. 1 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1892</b>
9. AGE (In years last birthday) <b>66 yrs</b>		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) <b>BROKERnce</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Rudolph Ahring</b>	
13b. MOTHER'S MAIDEN NAME <b>Marie Elise Tieman</b>		14. NAME OF HUSBAND OR WIFE <b>Late Willis Malone</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>496-36-7461</b>	17. INFORMANT Address <b>Mrs. Ann Hohlt, 5370 Claxton Ave. 20</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma ovary</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>175.0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE . HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> NOT WHILE 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 <b>2-20-58</b> to <b>10-1-58</b> and last saw her alive on <b>10-30-1958</b> Death occurred at <b>12:15 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John E. Shaner M.D.</b> (Degree or title)		22b. ADDRESS <b>3720 Washington</b>	
22c. DATE SIGNED <b>11-3-58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>11/4/58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	
23d. LOCATION (City, town, or county). <b>St. Louis County, Missouri</b>		23e. DATE RECD. BY LOCAL REG. <b>NOV 3 '58</b>	
24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD.</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	

1-5 P.M. Monday

File in city

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 *John A. Miller* .....

Licensed Embalmer No. *4186* .....

P. O. Address *St. Louis* .....

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.