

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960

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-60-024744

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **6282**

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                  |  | Length of stay in 1b<br><b>Life</b>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. John's Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS (If outside, give location)<br><b>4015 Darby Ave.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                               |   |   |                                     |   |
|--|-------------------------------|---|---|-------------------------------------|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Virginia</b> Middle <b>M.</b> Last <b>Mallon</b> |                               |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>19th.</b> Year <b>1960</b> |                                     |   |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>W.</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/31/1915</b>                                    | 9. AGE (last birthday)<br><b>45</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ |

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secty. Dr. John J. Hammond</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b> |
|--|-----------------------------------|--|--|

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|--|---|-----------------------------|
| 13a. FATHER'S NAME<br><b>Joseph Mallon</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Delia Power</b> | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

|   |                         |  |
|---|-------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Miss Dorothy Mallon, 4015 Darby Ave.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of breast bilateral</b><br>DUE TO (b) <b>with general metastases</b><br>DUE TO (c) <b>170x</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b><br><b>1 year</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT SUICIDE HOMICIDE<br><b>No No No.</b> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|---|--|--|

|   |  |  |  |                            |       |
|---|--|--|--|----------------------------|-------|
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year | 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<br><b>St. Louis</b> | COUNTY<br><b>St. Louis</b> | STATE |
|---|--|--|--|----------------------------|-------|

|  |  |
|--|--|
| 21. I attended the deceased from <b>June 5 - 1959</b> to <b>June 19 - 1960</b> and last saw her alive on <b>June 19 - 1960</b><br>Death occurred at <b>6:38 p.m.</b> on <b>June 19 - 1960</b> at <b>6:35 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |
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|   |                   |                                     |                                    |
|---|-------------------|-------------------------------------|------------------------------------|
| 22a. SIGNATURE<br><b>John J. Hammond M.D.</b> | (Degree or title) | 22b. ADDRESS<br><b>634 N. Grand</b> | 22c. DATE SIGNED<br><b>6/20/60</b> |
|---|-------------------|-------------------------------------|------------------------------------|

|   |                               |   |   |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>6/22/1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Missouri</b> |
|---|-------------------------------|---|---|

|  |                                      |  |  |
|--|--------------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><b>Arthur J. Donnell</b> | ADDRESS<br><b>3840 Lindell Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUN 20 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |
|--|--------------------------------------|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mab*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis Million

Licensed Embalmer No. 356

P. O. Address 3840 L...

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.