

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 17 1960

-60-032570
 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7921**

| | | | | | | | |
|--|---|---|--|--|---|--|--|
| 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, give TOWNSHIP only) OR TOWN ST. Louis, Mo. | | Length of stay in 1b 21 yrs. 7 mo. 16 days. | c. CITY OR TOWN St. Louis, Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1213 South 7th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First EFFIE Middle MAY Last MALLORY | | | 4. DATE OF DEATH Month July Day 28th Year 1960 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-10-85 | 9. AGE (last birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic (formerly) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Stanford, Ill. | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Sarah (McConkil) | | 14. NAME OF HUSBAND OR WIFE Roy Mallory | | | |
| 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 State Hospital Records Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) Pulmonary emphysema DUE TO (c) 527.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mental deficiency, with psychosis | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 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 12-12-38 to 7-28-60 and last saw her alive on 7-28-60 Death occurred at 1:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. L.N. McCullough, M.D. | | | | | | | |
| 22a. SIGNATURE L.N. McCullough M.D. (Degree or title) | | | 22b. ADDRESS 5400 Arsenal St. | | 22c. DATE SIGNED 7-29-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) AUG 31 1960 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| 24. FUNERAL DIRECTOR Rowland Mortuary Svc. | | ADDRESS 4104-06 Manchester | 25. DATE RECD. BY LOCAL REG. AUG 11 1960 | | 26. REGISTRAR'S SIGNATURE Carl Smith, M.D. <i>mjs</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY-AFFIDAVIT OF

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 _____

Licensed Embalmer No. _____

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.