MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 0 1960 — Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 10580 — STATE FILE NUMBER 60-039980

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess Hospital — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3121 Gurney Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ANTHONY — Middle: A. — Last: MALON
4. DATE OF DEATH: Month: Oct. — Day: 29 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-23-1902
9. AGE (last birthday): 58 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker-National Biscuit Company
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Frank Malon
13b. MOTHER'S MAIDEN NAME: Stella Tomczyk
14. NAME OF HUSBAND OR WIFE: Mary F. Malon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 494-03-8681
17. INFORMANT: Mary F. Malon — Address: 3121 Gurney Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma Rt Bronchus — INTERVAL BETWEEN ONSET AND DEATH: Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): with metastasis
DUE TO (c): 162.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Fibrinous Hemorrhagic Pericarditis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 8-26-58, to 10-29-60 and last saw ~~her~~ him alive on 10/29/60.
Death occurred at 5:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Arnold G. Klein M.D. (Degree or title)
22b. ADDRESS: 2632 S. Kingshighway
22c. DATE SIGNED: 10/31/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov. 2, 1960
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Kriegshauser — ADDRESS: 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: NOV 1 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT — 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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed William B White

Signature of Student Embalmer

Licensed Embalmer No. 429

P. O. Address 4228 [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.