

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004174

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 57

AMENDED

FILED JAN 11 1962

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>60-yrs.</u> | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4342a Laclede Ave.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4342a Laclede Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Buena</u> Middle <u>Maleas</u> Last | | | 4. DATE OF DEATH Month <u>January</u> Day <u>3rd.</u> Year <u>1962</u> | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</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>1/19/1881</u> | 9. AGE (last birthday) <u>80</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>New Haven, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | | 13a. FATHER'S NAME <u>Zachary B. Shelton</u> | | 13b. MOTHER'S MAIDEN NAME <u>Carolina Link</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Mr. John Maleas</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr. John Maleas, 4342a Laclede Ave.</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>Bronchopneumonia left side</u> DUE TO (b) <u>Parkinson's Disease</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>generalized arteriosclerosis, 350x</u> | | 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 | |

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| 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 <u>11</u> 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 <u>St. Louis</u> | | 20g. COUNTY <u>St. Louis</u> | | 20h. STATE <u>Missouri</u> | |

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| 21. I attended the deceased from <u>November 10th 1961</u> to <u>Jan 3, 1962</u> and last saw her <u>alive on Jan 2nd 1962</u> Death occurred at <u>5:30 am.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>Domini J. Verda M.D.</u> | | 22b. ADDRESS <u>4500 Live St</u> | | 22c. DATE SIGNED <u>1-3-1962</u> | |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>1/5/1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Arthur J. Connolly</u> | | ADDRESS <u>3840 Lindell Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>JAN 3 1962</u> | | 26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u> | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4699

P. O. Address 3840 Lumb

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.