

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017044

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

318

1003

3807

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

FILED APR 25 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		c. CITY OR TOWN <b>ST. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ALEXIAN BROS HOSP</b>		d. STREET ADDRESS (If outside, give location) <b>3520 S. JEFFERSON</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES EDWARD MALLOY</b>			4. DATE OF DEATH Month Day Year <b>APRIL 9, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 13, 1887</b>
9. AGE (last birthday) <b>74</b>		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) <b>RETIRED BEER TASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bused</b>	11. BIRTHPLACE (City and state or country) <b>ST. Louis Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>JOHN MALLOY</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY Connolley</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARIE MAHON</b>		Address <b>5470 Genevieve</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Subar left</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>490X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 a.m. p.m. 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		COUNTY STATE	
21. I attended the deceased from <b>Feb 3<sup>d</sup> 1962</b> to <b>4/9/62</b> and last saw her/him alive on <b>4/9/62</b> Death occurred at <b>935P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank D. Jones mo.</b>		22b. ADDRESS <b>812 Olive</b>	
22c. DATE SIGNED <b>4/11/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>April 12, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEM</b>		23d. LOCATION (City, town, or county) (State) <b>ST. Louis Mo.</b>	
24. FUNERAL DIRECTOR <b>Thomas Kuntz</b>		ADDRESS <b>2906 Brooks</b>	
25. DATE RECD. BY LOCAL REG. <b>4-11-1962</b>		26. REGISTRAR'S SIGNATURE <b>Joan Smith, M.D.</b>	

Dr. Sumner Price 10-12-12  
Wendy Bell 3-12-12  
626-1234

**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 Wendy J. Thompson  
Licensed Embalmer No. 4861  
P. O. Address Box 5 Mo

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.