

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH29850  
STATE FILE NUMBER 7461

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

|  |                           |   |  |   |   |
|--|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN St. Louis  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br>38 Enroute City Hospital  |                           | Length of stay in 1b<br>DOA   | STREET ADDRESS 4254 N. Florissant (If outside, give location)  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Lucille O'Malley   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>August 6, 1957   |   |   |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Feb. 3, 1891   |   | 9. AGE (In years last birthday)<br>66   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Cleaner & Presser   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br>Lawrenceville, Ill. | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |
| 13. FATHER'S NAME<br>John Maloy  |                           |   | 14. MOTHER'S MAIDEN NAME<br>Sadie Fail   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.<br>494-24-5461  |  | 17. INFORMANT Address<br>Jesse Maloy, Logansport, Ind.            |   |
| 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) Coronary Occlusion<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Sclerosis<br>DUE TO (c) Pulmonary Fibrosis |                           |   |  |   | 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)<br>420.1   |                           |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour Month, Day, Year<br>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 _____ to _____ and last saw her/him alive on _____<br>Death occurred at 2:15 P. M. on the date stated above; and to the best of my knowledge, from the causes stated  |                           |   |  |   |   |
| 22a. SIGNATURE (Degree or title)<br>Patrick J. Taylor, Coroner   |                           |   | 22b. ADDRESS<br>1300 Clark   |   | 22c. DATE SIGNED<br>8-9-57  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |                           | 23b. DATE<br>8-9-57   | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cemetery   |   | 23d. LOCATION (City, town, or county) (State)<br>St. Louis Co., Mo.                               |
| 24. FUNERAL DIRECTOR ADDRESS<br>Albert H. Hoppe, 4700 Washington Blvd.   |                           | 25. DATE RECD. BY LOCAL REG.<br>AUG 9 57  |  | 26. REGISTRAR'S SIGNATURE<br>J. Earl Smith, M.D.<br>S.P.          |   |

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Melvin J. Kemper*

Licensed Embalmer No. *4405*

P. O. Address *4911 Wash  
St. Louis, Mo.*

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