

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

10552

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Primary Registration District No. **1003**

Registered No. **13174**

City **St. Louis** (No. **Jewish Hospital**)

St. .... Ward)

**2. FULL NAME**

(a) Residence No. **#5100 1/2 Kensington Ave.**

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da. **12**

How long in U.S., if of foreign birth?

yrs.

mos.

da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

**Female. White Married.**

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OR (OR) WIFE OF

**Joseph A. Matz.**

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

**Nov 21<sup>st</sup> 1885**

7. AGE

YEARS **41.**

MONTHS **4.**

DAYS **10.**

If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

**at home**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

**Berlin, Germany**

(STATE OR COUNTRY)

10. NAME OF FATHER

**Isadore Godale**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Germany**

12. MAIDEN NAME OF MOTHER

**Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Germany**

14.

INFORMANT

(Address)

**J. A. Matz #5100 1/2 Kensington**

15.

FILED

1927

APR -1

19

**Maub Staresoff**

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

**3 / 31 19 27**

17.

I HEREBY CERTIFY, That I attended deceased from **8/2**, 19**26**, to **3/31**, 19**27**, that I last saw h. **27**... alive on **3/31**, 19**27**, and that death occurred, on the date stated above, at **8 P. M.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Carcinoma of Cervix uteri**

**46 46**

(duration) **2** yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY)

**Heart Mitralis**

(duration) .... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

**Do not know**

DID AN OPERATION PRECEDE DEATH?

**No** DATE OF .....

WAS THERE AN AUTOPSY?

**Yes -**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

**2. Fischel, M. D.**

(Address)

**400 Metropolitan St.**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

**Valhalla Crem.**

**4-3-27**

20. UNDERTAKER

**C. R. Rupton**

ADDRESS

**449 Olive Street**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

