

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

Do not use this space.

38634

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1907**

City **St. Louis Mo** (No. **Missouri Pacific Hospital**)

File No. _____
Registered No. **11038**

2. FULL NAME

Mrs. Anna Mattis

(a) Residence. No. **3957 Cleveland** St. **17** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF *J. A. Mattis*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 16 1850*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 11 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *France*

10. NAME OF FATHER *Anna Otzenberger*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *France*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT (Address) *Gen. P. Mattis 5621 Coburn Ave*

15. FILED *Nov 12 1929* *W. H. Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 11 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 10 1929*, to *Nov 11 1929* that I last saw her alive on *Nov 10 1929*, and that death occurred, on the date stated above, at *4:14 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myocarditis
Senile
93 C
1820 (duration) *Seven* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *90 C* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *R. R. Means* M. D.
Nov. 11 1929 (Address) *1755 S. Grand*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **DATE OF BURIAL**

W. H. Olive Cemetery *Nov 13 1929*

20. UNDERTAKER **ADDRESS**

Am. Robert *1905 S Grand*

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.

23
9

31

