

REC'D MAY 10 1939

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

13692
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township 1st Primary Registration District No. 1446
(c) City St. Louis, Mo (d) Street No. 1100 Gen Hosp St. 1100
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Best Matthews
(a) Residence, No. 504-W-16 St St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED D.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-8-1877
7. AGE YEARS 61 MONTHS 3 DAYS 25 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Fabrics
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas
13. NAME Ha. Matthews
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y.
15. MAIDEN NAME unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 1st
17. INFORMANT Records Clerk
(ADDRESS) 1100 Gen Hosp
18. BURIAL, CREMATION, OR REMOVAL Crematory DATE 4-5-39
19. FUNERAL DIRECTOR (ADDRESS) St. Louis, Mo
20. FILED Apr 5 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-19-39
22. I HEREBY CERTIFY, That I attended deceased from 3-7-39 1939, to 3-29-39, 1939.
I last saw him alive on 3-29-39 1939. Death is said to have occurred on the date stated above, at 12 1/2 a.m.
The principal cause of death and related causes of importance were as follows:
Carcinoma of Lung
Pulmonary Tuberculosis
Other contributory causes of importance: 47
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) P. J. De Maria M. D.
1100 Gen Hosp (Address) St. Louis, Mo

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.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.