

MO. AUA 22 1940

13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26276

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1523

1. PLACE OF DEATH: St. Louis  
 (a) County \_\_\_\_\_  
 (b) City or town Lemay, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3666a Weber Rd.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 20 yrs  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
Missouri  
 (a) State \_\_\_\_\_ (b) County St. Louis  
3666a Weber Rd.  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME HENRY MATT 300  
 3. (b) If veteran, name war. --  
 3. (c) Social Security No. --

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 17  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Josephine Matt 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased April 14 1868  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct - 6 1937 to Aug 17 1940  
 that I last saw him alive on Aug 15 1940  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
72 4 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cancer of oesophagus 10-mo.  
 Due to \_\_\_\_\_  
 Due to 46

9. Birthplace Switzerland  
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

10. Usual occupation Wax blender  
 11. Industry or business St. Louis Wax Co.

MOTHER FATHER  
 12. Name Jonas Matt  
 13. Birthplace Europe  
 (City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace Europe  
 (City, town, or county) (State or foreign country)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
707 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant Josephine Matt  
 (b) Address 3666a Weber Rd.

17. (a) burial (b) Date thereof Aug. 20/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Park Lawn

18. (a) Signature of funeral director Fendler Und. Co.  
 (b) Address 7420 Michigan Ave.

19. (a) AUG 20 1940 (b) M. C. Meyer, M.D.  
 (Date received local Registrar) (Registrar's signature)

Signature Drew J. G. G. G. (M. D. or other) 1160  
 Address 706 E. Michigan Date signed Aug 17

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

ES

**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

*Clayton E. Fendley*

Licensed Embalmer No. *4448*

P. O. Address *St. Louis*

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, fact should be so stated above.