

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39858**

FILED DEC 7 1940
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Registration District No. **784** Primary Registration District No. **200** Registrar's No. **2254**

1. PLACE OF DEATH:
(a) County **St. Louis County**
(b) City or town **Jefferson Barracks**
(c) Name of hospital or institution: **Veterans Administration Facility**
(d) Length of stay: In hospital or institution **Admitted 7/26/40.**
In this community **unknown.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois.** (b) County _____
(c) City or town **Benton**
(d) Street No. **916 Church Street**
(e) If foreign born, how long in U. S. A.? **unknown.** years.

3. (a) PRINT FULL NAME **Matt Masie**
3. (b) If veteran, name war **World War** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 29 1881**

8. AGE: Years **59** Months **3** Days **0** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Miner**

11. Industry or business **Coal Mining.**

12. Name **Unavailable**

13. Birthplace **Unavailable** (City, town, or county) (State or foreign country)

14. Maiden name **Unavailable**

15. Birthplace **Unavailable** (City, town, or county) (State or foreign country)

16. (a) Informant **M. Schullig**
(b) Address **Clinical Clerk, VAF, Jeff. Bks., Mo.**

17. (a) **REMOVAL** (b) Date thereof **NOV. 30. 40**
(c) Place: burial or cremation **BENTON, ILLINOIS**

18. (a) Signature of funeral director **Chaffmeister**
(b) Address **7814 S. Boulevard**

19. (a) **NOV 30 1940** (b) **D. R. Mays**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **29th**
year **1940** hour **5:20** minute _____ p.a.m.

21. I hereby certify that I attended the deceased from **July 26,** 19 **40**, to **November 29,** 19 **40**
that I last saw him alive on **November 29,** 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Osteo-mylitis, left femur and fibula.** Duration **6 months**

Due to _____
Due to _____ **154**

Other conditions **Infection, pyogenic, staphylococcus, left thigh. 1 month.**

Major findings: **Operated- Amputation, thigh, above knee, Oct. 9, 1940.**
Of operations **Re-amputation, upper third, left thigh.**
Of autopsy **no autopsy. 11/29/40.**

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? **701**

23. Signature **C. W. HUGHES, M.D.** (M. D. or other) **1**
Address **Chief Medical Officer.** Date signed **11/29/40**

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

Linus C. Hoffmeister

Licensed Embalmer No.

~~3871~~ 3871

P. O. Address

7814 S Broad

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.