

FILED JUN 9 1944

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

- (a) County.....
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
 (Specify whether
 In this community 6 years
 years, months or days)

3. (a) PRINT
FULL NAME

Mary Matthews

3. (b) If veteran,
name war

NONE

3. (c) Social Security
No.

NONE

4. Sex female 5. Color or
race col. 6. (a) Single, widowed, married,
/ divorced married
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased 12 9 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 5 17 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER
 12. Name Taylor Osler
 13. Birthplace unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Boden
 15. Birthplace Tenn.
 (City, town, or county) (State or foreign country)

16. (a) Informant Arizona Mc Neal

(b) Address 3129a Franklin

17. (c) Father Dickson (b) Date thereof 5-31-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson's

18. (c) Signature of funeral director Alvin Dailed

(b) Address 3506 Franklin

19. (a) MAY 31 1944 J. F. Breda
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County 000
 (c) City or town St. Louis, 9
 (If outside city or town limits, write "RURAL") 11
 (d) Street No. 3129a Franklin
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26,
 year 1944 hour 12 minute 40 P.M.
 21. I hereby certify that I attended the deceased from May
18, 1944, to May 26, 1944,
 that I last saw her alive on May 26, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 6days

Due to 107

Due to

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?

While at work?..... (Specify type of place) (c) Means of injury 5

23. Signature Alvin Moore (M. D. or other)
 Address Bo. White Date signed 5/29/44

NOV 28 1944

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..... *James W. Hanson*
Licensed Embalmer No..... *3522*
P. O. Address..... *3506 Franklin*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1416

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Matthew

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Not obtained 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 34 Months 5 Days 10 (Unless than one day, min.)

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

10. Usual occupation Day work

11. Industry or business _____

MOTHER FATHER { 12. Name Taylor Osler

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

14. Maiden name Mary Bolden

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

16. (a) Informant Shirley M. Smith

(b) Address Homer G. Phillips Hospital

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Data received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 3129 a Franklin (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26, year 1944 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from May 18, 1944 to May 26, 1944; that I last saw the deceased alive on May 26, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia (autopsy) apt. 6 days

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Alva Moore (M. D. or other)

Address Ho. White Date signed 5/27/44

SUPPLEMENTARY

107

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10573