No. 2
M—2-43
5-17-39
X35097

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29237

FILED SEP 18 1945

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8058

1. PLACE OF DEATH:
(a) County: St Louis
(b) City or town: St Louis Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 6 Hrs (Specify whether years, months or days) In this community: 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: do
(c) City or town: St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 2746 Lucas Ave. (If rural, give location) ? 21
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Jesse Mathews
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male 2
5. Color or race: Col,
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: July (Month) 20 (Day) 1897 (Year)
8. AGE: Years 48 Months 1 Days 27 If less than one day hr. min.
9. Birthplace: Washington County (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation: Porter
11. Industry or business: Fairground Hotel
FATHER 12. Name: Jonas Mathews
FATHER 13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name: Harriott ?
MOTHER 15. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Angie Wilkins
(b) Address: 2816 a Gamble St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Pk., Cem.
18. (a) Signature of funeral director: Ellis Funeral Home
(b) Address: 2820 Stoddard St
19. (a) SEP 15 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 11 year 1945 hour 6 minute 260 A.M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Chronic Arteriosclerosis
Due to: Hypertension
Other conditions (Include pregnancy within 3 months of death): 93
Major findings: Of operations:
Of autopsy:

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)
While at work? (Specify type of place) (e) Means of injury: 5
23. Signature: [signature] (M. D. or other)
Address: [signature] Date signed 9/13/45

(Licensed Embalmer's Statement on Reverse Side)

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 L Boyp

....., Registered Apprentice No. M,

working under my personal supervision.

Signed Lonnie Boyp

Licensed Embalmer No. 2946

P. O. Address St Louis MO

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.