

FILED JAN 21 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 103

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1813 Lucas Ave 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... 27 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis
(c) City or town St. Louis MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1813 LUCAS AVE
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Sarah Matthews
3. (b) If veteran, name war no 3. (c) Social Security No. 720

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 20th
year 1946 hour 11 minute 30 P. 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.

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Joseph P. Matthews 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Nov 24 1880
(Month) (Day) (Year)

Immediate cause of death Cardio-Vascular
Renal diseases
Due to 1/2 a
Due to.....
Other conditions (Include pregnancy within 3 months of death).....
Major findings: Of operations.....
Of autopsy.....

8. AGE Years abt 57 Months 7 Days..... If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Ill (State or foreign country)

10. Usual occupation.....
11. Industry or business Housewife
12. Name Edward Ford
13. Birthplace MO (City, town, or county) (State or foreign country)
14. Maiden name Lula Jones
15. Birthplace Ill (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?
(Specify type of place) While at work? (e) Means of injury.....

16. (a) Informant Joseph P. Matthews
(b) Address 1813 Lucas Ave
17. (a) Removal (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial, or cremation St. Louis Ill
18. (a) Signature of funeral director J. M. Green
(b) Address 3517 Valde Ave
19. (a) JAN 8 1946 (b) J. F. Bredeok
(Date received local registrar) (Registrar's signature)

23. Signature Detrick E. Dyer (M. D. or other)
Address..... Date signed 1/21/46

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

MOTHER FATHER

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.....

Melvin Edward Green Registered Apprentice No. *383*
working under my personal supervision.

Signed..... *M. E. Green*

Licensed Embalmer No. *1173*

P. O. Address *3517 Soledad av*

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. Feb
Registrar's No. 103

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Sarah Mathews

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

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

6. (b) Name of husband or wife Joseph 6. (c) Age of husband or wife if alive 65

7. Birth date of deceased (Month) Nov (Day) 24 (Year) 1879

8. AGE: Years 57 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof Jan 7 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 2 Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2840 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 11 1946

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