

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34628

State File No.

FILED NOV 12 1946

Registration District No.

Primary Registration District No.

3863

Registrar's No.

3233

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
D. O. A. St. Louis County Hospital
(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 LAWRENCE H. MATTI

3. (b) If veteran, name war _____
3. (c) Social Security No. 490-01-3050

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary B. Matti 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased November 3 1898
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Reverend Presb. Co.

MOTHER FATHER

11. Industry or business _____
12. Name Joseph Matti
13. Birthplace Italy
(City, town, or county) (State or foreign country)
14. Maiden name Adler
15. Birthplace Italy
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary B. Matti
(b) Address 305 Fieldstone Parkwood
17. (a) Burial (b) Date thereof 11-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Church
18. (a) Signature of funeral director James P. ...
(b) Address ...
19. (a) 11-2-46 (b) ...
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 305 Fieldstone
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1946 hour 1 minute 57P M.

21. I hereby certify that I attended the deceased from Feb 26 1946 to Oct 21 1946
that I last saw him alive on Oct 24 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage

Due to cancer of Larynx with tracheal extension.

Due to 470

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)
(c) Means of injury _____

23. Signature R. H. Milligan (M. D. or other) _____
Address 607 N Grand Date signed Nov 1, 46

(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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Jalan M. Meyer*
Licensed Embalmer No. *3288*
P. O. Address *331 S. Kund Rd*

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 DEATHState File No. NovRegistration District No. 317Primary Registration District No. 3063Registrar's No. 2233

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
D.O.C. St Louis County Hosp.
(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 Lawrence H. Mattle3. (b) If veteran,
name war.....3. (c) Social Security
No. 490-01-30504. Sex m5. Color or
race w6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
alive 37. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

55402

hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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 Mrs. Mary B. Mattle(b) Address 305 Welda Ave. Kirkwood, Mo.17. (a) Burial(b) Date thereof 11-2-46
(Month) (Day) (Year)(c) Place: burial or cremation Old St Peter's Paul Cem.18. (a) Signature of funeral director Weyer - Fitzinger & Fur. Co.

(b) Address.....

19. (a) 11-2-46(b) Paul J. Allen MD(Date received local registrar)(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis
 (c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
 (d) Street No. 305 Welda Ave
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day.....
 year 1946 hour..... minute 59 P.M.

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

Immediate cause of death.....
 Duration.....

Pulmonary tuberculosis

Due to.....

Due to Cancer of LarynxOther 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?
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature R. H. Milligan (M. D. or ~~other~~)Address 607 N. Grand Ave. St. Louis Date signed 11-7-46

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

MOTHER FATHER

34628