

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36537

State File No. _____

Registration District No. 377

Primary Registration District No. 3069

Registrar's No. 2194

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's 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 MATTIE M. MANN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Harvey W. Mann 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 23, 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 3 22 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John H. Daniel
13. Birthplace Kentucky /
(City, town, or county) (State or foreign country)
14. Maiden name Olivia Hullett
15. Birthplace Missouri O
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Oliva Weßsells
(b) Address 1313 Claytonia Terrace

17. (a) Burial (b) Date thereof Oct. 17, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Shepard Funeral Home
1167 Hamilton Avenue
(b) Address

19. (a) 10-17-47 (b) Beulah J. Sharp M.D.
(Date received local registrar) (Registrar's signature) Address 5730 Southworth

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town Richmond Heights 8
(If outside city or town limits, write "RURAL")
(d) Street No. 1313 Claytonia Terrace 3
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15, 1947
year 12 hour 15 minute _____ P. M.

21. I hereby certify that I attended the deceased from 13 may 1946 to 15 oct 1947
that I last saw h. er. alive on 15 oct 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 10 days
Due to Chc. myocarditis 10 yrs
Due to Chc. hypertension 16 yrs
93d

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 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? ()

While at work? _____ (Specify type of place) Means of injury _____
23. Signature Richard H. Ray (M. D. or other) M.D.
Address 5730 Southworth Date signed 16 oct 47

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

Dr. Richard Ray
5930 Southwood

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 Henry M. Brammer
Licensed Embalmer No. 4200
P. O. Address.....

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.