No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 8 1947

Registration District No. 217

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 40532

Registrar's No. 2498

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Robert Koch Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 164 days. (Specify whether
In this community 5 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County [redacted] 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4250 W. Cook 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country —

3. (a) PRINT FULL NAME Albert Charles Matthews

3. (b) If veteran, name war

3. (c) Social Security No. 426-36-0454

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single O

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased November (Month) 16, (Day) 1926 (Year)

8. AGE:

Years	Months	Days	If less than one day
21	0	12	— br. — min.

9. Birthplace Louisiana 1
(City, town, or county) (State or foreign country)

10. Usual occupation Tray maker

11. Industry or business Trunk factory

FATHER
12. Name Ben Matthews
13. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Angeline Craft
15. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records.
(b) Address Robert Koch Hosp.

17. (a) Shipping (Burial, cremation, or removal) (b) Date thereof 12-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation Amite City, La.

18. (a) Signature of funeral director Atkins Bros
(b) Address 3644 Finney ave

19. (a) 12-3-47 (Date received local registrar) (b) Cecil J Sharp MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28th
year 1947 hour 1 05 minute P. M.

21. I hereby certify that I attended the deceased from 6-17, 1947, to 11-28, 1947; that I last saw him alive on 11-28, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	6 months
Due to	
Due to 13b	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 O

23. Signature W.C. Banton II (M. D. ~~or other~~)
Address Robert Koch Hospital Date signed 11-29-47

Jefferson City Printing Co.

(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 me

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

working under my personal supervision.

Signed Louis V. Atkins

Licensed Embalmer No. 2842

P. O. Address: 364 Finney Ave

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.