

National Office of Vital Statistics  
FILED JUL 15 1948

State File No. 5939

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

## 1. PLACE OF DEATH:

(a) County.....  
 (b) City or town, St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Anthony's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution, March 6 to June 30  
 (Specify whether  
 In this community.....  
 years, months or days)

3. (a) PRINT FULL NAME Mother Mary Hilaria Matz, O.S.F.

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

4. Sex F / 5. Color or race White  
 6. (a) Single, widowed, married, divorced, Religious  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased January 31 1881  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	5	1	..... hr. .... min.

9. Birthplace Chicago, Illinois  
(City, town, or county) (State or foreign country)10. Usual occupation Religious

11. Industry or business.....

12. Name John Matz13. Birthplace Poland  
(City, town, or county) (State or foreign country)14. Maiden name Suzanne Sprengel15. Birthplace Poland  
(City, town, or county) (State or foreign country)16. (a) Informant Sister Constance  
3419 Gasconade Str.  
(b) Address.....17. (a) Burial (b) Date thereof 7/3/48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Villa St Joseph18. (a) Signature of funeral director Central Und. Ferguson(b) Address 1841 Cass ave19. (a) JUL 2 1948 (b) J. J. Budack  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3419 Gasconade Street  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30,  
year 1948, hour 1:45 minute P M.21. I hereby certify that I attended the deceased from March 5, 1948 to June 30, 1948  
that I last saw her alive on June 30, 1948  
and that death occurred on the date and hour stated above.Immediate cause of death Cardiac decompensation  
ration.Due to Hypertensive cardio-renal disease  
Due to Chronic NephritisOther conditions Left flaccid paralysis  
(Include pregnancy within 3 months of death)  
due to previous cerebral hemorrhage

Major findings: \_\_\_\_\_ PHYSICIAN

Of operations.....

Of autopsy.....  
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.....

23. Signature Victor H. Buehler D. or other) 0 7/2/48Address 3608 So. Grand Date signed 7/2/48

MOTHER: FATHER: 4

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

*John S. Denner*

Licensed Embalmer No. *4194*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.