

No. 300  
10.48

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3018

State File No. \_\_\_\_\_

510

1003

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2160 Lawrence</u>				d. STREET ADDRESS (If rural, give location) <u>2160 Lawrence</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ADA</u>		b. (Middle) <u>KAY</u>		c. (Last) <u>MATHIAS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 30 49</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>		8. DATE OF BIRTH <u>July 13, 1873</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>William Kay</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Crabtree</u>	
14. NAME OF HUSBAND OR WIFE <u>B. F. Mathias</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Walter K. Mathias</u>				ADDRESS <u>320 N. 4th St</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Arteriosclerosis</u>							
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u>							
DUE TO (c) <u>Hypertension, Arteriosclerosis</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>920</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4407</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u> <u>Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1945</u> to <u>1/30 1949</u> , that I last saw the deceased alive on <u>1/29 1949</u> , and that death occurred at <u>3:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George Becker M.D.</u>				23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>1/30/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Feb. 2, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>4947 W. Florissant Mo.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 1 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Rosater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Kou P. U. Co</u>		ADDRESS <u>2707 N. Grand</u>	

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Stanley H. Dixon

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.