

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10393

State File No. ....

BIRTH NO. .... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2355

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>MO</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>	
c. LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>1773 Nicholson Pl</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>1773 Nicholson Pl</u>		d. STREET ADDRESS (If rural, give location) <u>1773 Nicholson Pl</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>William</u>	b. (Middle) <u>H.</u>	c. (Last) <u>Matkin</u>	<u>Mar. 14 - 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>D</u>	8. DATE OF BIRTH <u>Feb. 6 - 1906</u>	9. AGE (In years last birthday) <u>43</u>	10. UNDER 1 YEAR Days <u>1</u> Hours <u>8</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Madison County, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <u>Wm. H. Matkin</u>		13b. MOTHER'S MAIDEN NAME <u>Emma B. Ornett</u>		14. NAME OF HUSBAND OR WIFE <u>Charlotte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI #2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Wm. H. Matkin</u> ADDRESS <u>1773 Nicholson Pl</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDITIS - Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Don't know</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>ANGINA PECTORIS</u>		DUE TO (c) <u>9/2</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>H2 2 2</u>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Oct 22, 1948 to Feb 22, 1949, that I last saw the deceased alive on Feb 22, 1949, and that death occurred 9:20 AM, from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>Paul Conner MD</u>		23b. ADDRESS <u>500 S. AGRAVOIS St. Louis 16 Mo</u>		23c. DATE SIGNED <u>3-14-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-16-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL</u>	
24d. LOCATION (City, town, or county) (State) <u>JEFF. BKS. MO.</u>					

DATE REC'D BY LOCAL REG. <u>MAR 15 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Losater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Q. W. McLaughlin</u> ADDRESS <u>2601 Lafayette</u>	
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Mr. John Cornell  
5005 9 Gravois

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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.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*C W Cooper*

Licensed Embalmer No. *3830*

P. O. Address *2301 Lafayette*

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.