

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35395

State File No. 8978

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer C. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4330 Ashland	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) William	b. (Middle) Mathews	c. (Last)	Month	Day	Year
			Oct.	17	1949

5. SEX male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 21, 1890	9. AGE (In years last birthday) 59	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? USA
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10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Uniontown, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Albert Mathews		13b. MOTHER'S MAIDEN NAME Mollie Bronson		14. NAME OF HUSBAND OR WIFE Amy Mathews	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) yes #1		16. SOCIAL SECURITY NO. #1	17. INFORMANT'S SIGNATURE OR NAME Amy Mathews 4330 Ashland			ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease with		Conestive Failure				Undet.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				
		DUE TO (b) Undetermined				
		DUE TO (c)				
		II. OTHER SIGNIFICANT CONDITIONS				
		Conditions contributing to the death but not related to the disease or condition causing death.				Cerebral Thrombosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) 93	
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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? 443X		
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22. I hereby certify that I attended the deceased from 10-10, 1949, to 10-17, 1949, that I last saw the deceased alive on 10-17, 1949 and that death occurred at 9:10 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Hedrick, D. U.		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 10-18-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10/21/49	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 19 1949 J. B. Rosster	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry		ADDRESS 4202 Finney Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 7 1949

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 Leroy W. Pannister

Licensed Embalmer No. 4523

P. O. Address 3880 Easton 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.