

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2870
State File No.
Registrar's No. 570

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROMER G. PHILLIPS HOSPITAL		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
3. NAME OF DECEASED a. (First) Mattie		c. (Last) Agatsee	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) Jan 15, 1950	
5. SEX F 3	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 10, 1896
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Jon Moore		13b. MOTHER'S MAIDEN NAME Annie Holliday	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Leri Moore 1121 1/2 N. Venturato	
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) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) 3011	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 149 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE Joseph M. ...		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 1/19/50		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE Jan 21/50		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem St. Louis	
24d. LOCATION (City, town, or county) (State) MO		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE F. H. Hiller 4214 Delmar		ADDRESS	

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

2009
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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 *J. C. Allen*

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.