

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3790

State File No.

FILED JAN 28 1953

BIRTH NO. _____ REG. DIST. NO. **818** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0258**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 13 yrs		d. STREET ADDRESS (If rural, give location) 617 N Beaumont	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) Mattie			4. DATE OF DEATH (Month) (Day) (Year) Jan. 4 1953		
a. (First)		b. (Middle)		c. (Last) Solomon	

5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH About, 1874	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
-------------------------	------------------------------------	--	--	--	---------------------------	--------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? U S A
--	--	--	--

13a. FATHER'S NAME Not known	13b. MOTHER'S MAIDEN NAME Not known	14. NAME OF HUSBAND OR WIFE Henry Solomon (Deceased)
--	---	--

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 Elizabeth Rhodes, 2601 N Whittier St	ADDRESS
--	-------------------------	--	---------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive Heart Failure		Undet.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Failure DUE TO (c)		"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 4200
---	--	--

22. I hereby certify that I attended the deceased from 1-1, 19 53 to 1-4, 19 53, that I last saw the deceased alive on 1-4, 19 53 and that death occurred at 2:02p m., from the causes and on the date stated above.

23a. SIGNATURE Charles P. Farden, M.D.	(Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 1-8-53
--	-------------------	---	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-12-1953	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. JAN 10 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE People's Und. Co., 3100 Franklin	ADDRESS
--	---	---	---------

(Licensed Embalmer's Statement on Reverse Side)

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.

Student
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alde

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.