

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **2457**
Registrar's No. **0876**

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) a. STATE MISSOURI b. COUNTY _____				
b. CITY OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) 0		c. CITY OR TOWN ST. LOUIS				
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER G. PHILLIPS HOSP				d. STREET ADDRESS (If rural, give location) 2219 2700th GAMBLE				
3. NAME OF DECEASED (Type or Print) MATT DANIELS			a. (First) _____		b. (Middle) _____		c. (Last) DANIELS	
4. DATE OF DEATH 1-27-55		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2		8. DATE OF BIRTH 1893 6-20-1892		9. AGE (In years last birthday) 7 9		
5. SEX MALE		6. COLOR OR RACE COLORED		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY _____		
11. BIRTHPLACE (City and State or Foreign Country) Calif. Ky.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME EDMOND DANIELS			13b. MOTHER'S MAIDEN NAME ELMIRA		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME John Daniels ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. Ruptured Esophageal Ulcer; 2. Gastric Ulcer; 3. Hypernephroma;		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) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____		
19a. DATE OF OPERATION 1-27-55		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) _____				
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? 180x				
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 9:55 P.M. , from the causes and on the date stated above.								
23a. SIGNATURE Joseph M. Quinn Deputy (Name or title) _____				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/31/55		
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 2-3-55		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) KOTTAWA, KY		
DATE REC'D BY LOCAL REG. JAN 31 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.F. WALTON 2707 Stoddard				

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 Aldine*

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.