

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38609**
Registrar's No. **10230**

FILED DEC 2 1955

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute to City Hosp.		e. STREET ADDRESS 1519 Picker St.	(If rural, give location) 22310
3. NAME OF DECEASED (Type or Print) a. (First) URAH b. (Middle) c. (Last) MATTHEWS		4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 15, 1886
9. AGE (In years last birthday) 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and State or Foreign Country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joseph Matthews		13b. MOTHER'S MAIDEN NAME Mary (Unk)	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. Spanish Amer.		17. INFORMANT'S SIGNATURE OR NAME Clyde Matthews, 1519 Picker, St. L, Mo	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis 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 420.1	
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) m.		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 1301 m., from the causes and on the date stated above.			
23a. SIGNATURE James M Kelly		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 11-23-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-23-55	
24c. NAME OF CEMETERY OR CREMATORY Fairview		24d. LOCATION (City, town, or county) (State) Delta, Mo.	
DATE REC'D BY LOCAL REG. NOV 23 1955		25. FUNERAL DIRECTOR'S SIGNATURE McLAUGHLIN FUNERAL HOME, INC.	
REGISTRAR'S SIGNATURE Paul Smith MD		ADDRESS 301 Lafayette, St. Louis Mo	

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.....
Signature of Student Embalmer

Signed..... *James R. Chapman*

Licensed Embalmer No. *406*

P. O. Address *St. La*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.