

FILED OCT 16 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35425

STATE FILE NUMBER

318

1003

8706

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>ST. LOUIS NEW FAITH HOSP.</b>		Length of stay in 1b	STREET ADDRESS <b>4215 DRESSSELL</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAM</b>			First Middle Last <b>DE MATTEO</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 19 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 25, 1881</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL BAKERY</b>	11. BIRTHPLACE (City and state or country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>GIAEAMO DE MATTEO</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>355-07-2931</b>	17. INFORMANT Address <b>CHRISTINE HAZZARD 4215 DRESSSELL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial pneumonia</b> Condition, if any, which gave rise to cause of death (b) <b>due to</b> Condition, if any, which gave rise to cause of death (c) <b>due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>Senile &amp; Obesity</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		<b>491X</b>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <b>9/18/56</b> to <b>9/19/56</b> and last saw him alive on <b>9/19/56</b> Death occurred at <b>1 P. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Rose M. A. Bauer M.D.</b>			22b. ADDRESS <b>3731 Goodfellow</b>		22c. DATE SIGNED <b>9/20/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>SEPT. 22, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SS PETER &amp; PAUL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>COLLINSVILLE ILLINOIS</b>		
24. FUNERAL DIRECTOR ADDRESS <b>STROOT CARROLL 4600 NATURAL BRIDGE</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 21 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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DR BAUER  
2731 GOODFELLOW  
COL-7302  
1-4

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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.....  
Signature of Student Embalmer

Signed *M. W. Rueter*.....

Licensed Embalmer No. *48*

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.