No. 800
10-48

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

FILED DEC 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40201

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2776

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Robertson
c. LENGTH OF STAY (In this place): yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Porter Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo.
b. COUNTY: St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Robinson Hill
d. STREET ADDRESS (If rural, give location): Fee Fee Road

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle):
c. (Last): Matson

4. DATE OF DEATH (Month) (Day) (Year): 11-23-56

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 6-22-1881
9. AGE (In years last birthday): 75 — If under 1 year: Months: Days: If under 24 hrs.: Hours: Min.:

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

13a. FATHER'S NAME: Robert Matson
13b. MOTHER'S MAIDEN NAME: unk
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: unk
17. INFORMANT'S SIGNATURE OR NAME: Odell Samuel
ADDRESS: 4764 Northland

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Unknown natural causes

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
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Herbert R. Domke, M.D., Local Registrar
23b. ADDRESS: 651 S. Brentwood Blvd.
23c. DATE SIGNED: 11/30/56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-27-56
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis County Mo

DATE REC'D BY LOCAL REG.: 11-26-56
REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: J. McClondon
ADDRESS: 4535 Washington

(Licensed Embalmer's Statement on Reverse Side)

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 John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.