

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10706

State File No.

FILED APR 12 1957

318

1003

2704

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		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 (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) Lifetime		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 01 913 Mounds Street				e. STREET ADDRESS (If rural, give location) 2 269 913 Mounds St			
3. NAME OF DECEASED (Type or Print) MILDRED		a. (First)		b. (Middle) WILLIAMS		c. (Last) MASTERTSON	
4. DATE OF DEATH March 17 1957		4. DATE OF DEATH (Month) (Day) (Year)		4. DATE OF DEATH (Month) (Day) (Year)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX Female 3		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec 24 1906	
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days 23		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo 0	
12. CITIZEN OF WHAT COUNTRY? USA				13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Charles Mastertson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Charles Mastertson				ADDRESS 913 Mounds St			
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.							
MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease							
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Thrombosis							
DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201							
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)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from July 1952, to March 1957, that I last saw the deceased alive on March 17 1957, and that death occurred at 7:45 AM., from the causes and on the date stated above.							
23a. SIGNATURE A.B. Smith, M.D.				23b. ADDRESS 111 N. Jefferson Avenue		23c. DATE SIGNED 3-17-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-20-1957		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo	
DATE REC'D BY LOCAL REG. MAR 19 57		REGISTRAR'S SIGNATURE A.B. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Ave			

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

(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.....
Signature of Student Embalmer

Signed *Ester N. Harris*.....

Licensed Embalmer No. *4458*.....

P. O. Address *41817*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.