

FILED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19045

STATE FILE NUMBER

318

1003

5211

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

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. James | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | | Length of stay in 1b 3 days | | d. STREET ADDRESS 231 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Bessie Middle May Last Matlock | | | | 4. DATE OF DEATH Month June Day 2 Year 1957 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 11, 1892 | | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) Phelps Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME John Martin | | | | 14. MOTHER'S MAIDEN NAME Sarah Jane Woodward | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil. | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Ruth Jones, St. James, Missouri. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEPTEMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) INTRACAPILLARY GLOMERULOSCLEROSIS DUE TO (c) DIABETES MELLITUS. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 Mo's. 1 yr. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 260x | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | | |
| 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. | | | | | | | | |
| 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 July 18, 52 to June 2, 1957 and last saw her ^{her} _{him} alive on June 2, 1957 . Death occurred at 11:30 pm on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Label E. Koch, M.D. (Degree or title) | | | | 22b. ADDRESS 35 N. Central, Clayton, Mo. | | 22c. DATE SIGNED 6-3-57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 6-3-57 | 23c. NAME OF CEMETERY OR CREMATORY Matlock Cemetery | | 23d. LOCATION (City, town, or county) (State) St. James, Mo. | | | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, | | | 25. DATE RECD. BY LOCAL REG. JUN 3 '57 | | 26. REGISTRAR'S SIGNATURE Carl Smith Mo | | | |

JUN 14 1957

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 *John D. Derr*
Licensed Embalmer No. *71*
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.