

FILED SEP 4 1957

STANDARD CERTIFICATE OF DEATH

29680  
STATE FILE NUMBER 7868  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If outside, give location) 4362 Enright	
3. NAME OF DECEASED (Type or print) MATTIE		4. DATE OF DEATH 8 20 1957	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7-1883	
9. AGE (In years last birthday) 73		10. 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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (City and state or country) Camden, Ark.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alex Starlard		14. MOTHER'S MAIDEN NAME Elvira -- Seay	
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. None	
17. INFORMANT James Laster, 4362 Enright		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			INTERVAL BETWEEN ONSET AND DEATH 9 days Unknown
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.) 332x	
20c. TIME OF INJURY Hour Month, Day, Year		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from August 12 to August 20 and last saw her/him alive on August 19. Death occurred at 7:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M.E. Arnold M.D.		22b. ADDRESS 11 N. Jefferson Ave. St. Louis, Missouri	
22c. DATE SIGNED 8-21-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/26/57	
23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney		25. DATE RECD. BY LOCAL REG. AUG 22 '57	
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		S.P.	

(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 *Edward J. Flynn*.....

Licensed Embalmer No. *44*..

P. O. Address *4107 Finne*

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.