FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34420
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2197

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights	Inside Limits Yes X No ☐	c. CITY OR TOWN St. Louis	Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 33 St. Mary's Hosp.	Length of stay in 1b 1 Mo.	STREET ADDRESS (If outside, give location) 5 1232 Blackstone	Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	ELLEN		MATHEWS		September	1	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Nov. 15, 1876	80	9	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Ireland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dennis Naughton	Helen Dellano

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	None	Ann Decker	7135A Amherst

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Oesophageal obstruction — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Malignant mesenchymal tumor — 14 mos

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial degeneration. Rheumatoid arthritis 197X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 5 1956 to Sept. 1, 1957 and last saw her alive on 9/1/57

Death occurred at 4:20P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
C. Kleinschmidt	M.D.	5084 N. Grand	9/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	Sept. 4, 1957	Calvary Cemetery	St. Louis, Missouri

24. FUNERAL DIRECTOR	ADDRESS	25. DATE REC'D BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Ambruster Mortuary	6633 Clayton Rd.	9-3-57	Herbert R. Domke MD

(Licensed Embalmer's Statement on Reverse Side)

ASB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, ~~or by~~ ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 47

P. O. Address St. Lou

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.