

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3295  
STATE FILE NUMBER  
1164

FILED FEB 14 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MO</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>25 ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>124 779 AUBERT</u>	

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle Last <u>MATHEWS</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>29,</u> Year <u>1958</u>		
---	--	--	---	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1903</u>	9. AGE (In years last birthday) <u>54 YRS 8</u> Months Days Hours Min.
--------------------	---------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>BARBER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) <u>TALULLAH LA!</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
--	-----------------------------------	--	--

13a. FATHER'S NAME <u>WILLIS MATHEWS</u>	13b. MOTHER'S MAIDEN NAME <u>EMMA GORDON</u>	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Ruthie M. Rahlf 779 Aubert</u>
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation of the gall bladder</u> DUE TO (b) <u>Emphysema of the gall bladder</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>585x</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 <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 <u>1/26/58</u> to <u>1/29/58</u> and last saw her alive on <u>1/29/58</u> Death occurred at <u>2:01 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>W. Lightner M.D.</u>	22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>1/29/58.</u>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK Cem</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CITY MO</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>A.F. WALTON</u>	ADDRESS <u>2707 STODDARD</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 31 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, MD</u>
--	---------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S.P.

0.05 00 . . . .

1911

0.05

0 11100.12

. . . . .

**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 *H. Claude Gordon*

Licensed Embalmer No. *2489*  
P. O. Address *4575 Alder*

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.