

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH3297
STATE FILE NUMBER 427

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No.

427

1. PLACE OF DEATH a. COUNTY <i>Mo.</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Texas</i> b. COUNTY <i>Mc Allen</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Mc Allen</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Pacific Hospital</i>		Length of stay in lb <i>5 mo.</i>		d. STREET ADDRESS (If outside, give location) <i>33 417N-12th</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Allan</i> Middle Last <i>Matthews</i>			4. DATE OF DEATH Month <i>Jan.</i> Day <i>12</i> Year <i>1958</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 18, 1891</i>	9. AGE (In years last birthday) <i>66</i>	FUNDER YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R. R. Employee.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (City and state or country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13a. FATHER'S NAME <i>Andrew Matthews</i>			13b. MOTHER'S MAIDEN NAME <i>Not Known</i>			14. NAME OF HUSBAND OR WIFE <i>Mary Matthews</i>		
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. <i>—</i>		17. INFORMANT Address <i>Mary Matthews McAllen Texas</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branchiopneumonia</i> DUE TO (b) <i>Carcinoma involving ureter, lung, liver & lymph nodes.</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>4 mo</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Old fracture Rt. leg. & wrist 1992 F</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>On admission to the hospital. before he read</i>						
20c. TIME OF INJURY Hour Month, Day, Year <i>3:30 Sept 9, 1958</i>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Hospital</i>						
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <i>St. Louis</i>		COUNTY <i>Mo.</i>		STATE		
21. I attended the deceased from <i>Sept 9-1958</i> , to <i>Jan 12-58</i> and last saw her/him alive on <i>Jan 12-58</i> Death occurred at <i>10:05</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>J. D. Lembeck M.D.</i>				22b. ADDRESS <i>1755 S. Grand</i>		22c. DATE SIGNED <i>1-13-58</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1-14-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Valkalla Cem</i>		23d. LOCATION (City, town, or county) (State) <i>ST Louis Co Mo</i>		
24. FUNERAL DIRECTOR <i>A. Krow</i>			ADDRESS <i>2707 91st Grand</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 14 '58</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK-OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

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Doctor, coroner, etc. must use only standard manufacturer's form. No symbols. All diseases in Part I must be causally related.

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 *Loren E. Percy*

Licensed Embalmer No. *4094*

P. O. Address *St. Louis, Mo*

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.