

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027316

STATE FILE NUMBER

FILED AUG 1 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6960

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>3831 Lafayette</i>		d. STREET ADDRESS (If outside, give location) <i>3831 Lafayette</i>	
Length of stay in lb <i>9/17/58</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mattie</i> Middle <i>Paul</i> Last <i>0</i>			4. DATE OF DEATH Month <i>7</i> Day <i>11</i> Year <i>58</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/9/1871</i>
9. AGE (In years last birthday) <i>86</i>		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) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	11. BIRTH PLACE (City and state or country) <i>Springfield Mo</i>
12. FATHER'S NAME <i>George Harmon</i>		13. MOTHER'S MAIDEN NAME <i>don't know</i>	14. NAME OF HUSBAND OR WIFE <i>George</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>Mrs. E. Canavan 3831 Lafayette</i> 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) <i>Cerebral accident (10-12 hrs)</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <i>cardio-vascular disease present 8-14-58</i> DUE TO (c) <i>422.1</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Right hemiplegia present 8-14-58</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7-11-58</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 <i>8-14-58</i> to <i>7-11-58</i> and last saw her alive on <i>7-11-58</i> Death occurred at <i>5P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John Flynn BS MD</i>		22b. ADDRESS <i>1715 So. 39th St. St. Louis Mo</i>	22c. DATE SIGNED <i>7-12-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>7/14/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Missouri Crematory</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR <i>Jos. A. Howard 1619 So. Grand</i>		25. DATE RECD. BY LOCAL REG. <i>JUL 14 58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 *Lawrence O. Herling*

Licensed Embalmer No. *4979*

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.