

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045721

STATE FILE NUMBER

FILED JAN 12 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12195

300  
1-57

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Missouri</b><br>b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>St. Louis</b>                                       |   | c. CITY<br>OR<br>TOWN<br><b>St. Louis</b>  |   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| 25 FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION<br><b>City Hospital # 1</b>                     |   | Length of stay in lb<br><b>28yrs</b>   |   |
| d. STREET<br>ADDRESS<br><b>3046 Thomas St.</b>  |   | (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>MATTIE GREEN</b>  |   |  | 4. DATE<br>OF<br>DEATH<br>Month Day Year<br><b>Dec 14 1958</b>    |
| 5. SEX<br><b>Female 3</b>   | 6. COLOR OR RACE<br><b>Col</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Sept 22 1900</b>                           |
| 9. AGE (In years<br>last birthday)<br><b>58</b>   | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Material Sorter</b> | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Manufacturer</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Jackson Tenn</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   | 13a. FATHER'S NAME<br><b>Ale Harris</b>  |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Ann Bond</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>_____</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>         |   | 16. SOCIAL SECURITY NO.<br><b>499-03-9485</b>  |   |
| 17. INFORMANT<br>Address<br><b>Annie Mae Goff 2947 Thomas St</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drugs Pneumonia</b><br><b>(Empyema)</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) <b>518X</b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |   | 20a. ACCIDENT SUICIDE HOMICIDE<br><input 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.)                                      |   | 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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<br><b>St. Louis, Co.</b>   |   | 20g. COUNTY<br><b>Mo</b>   |   |
| 20h. STATE  |   | 21. I attended the deceased from _____ and last saw her/him alive on _____<br>Death occurred at <b>315 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |   |
| 22a. SIGNATURE (Name or title)<br><b>J. Earl Smith</b>  |   | 22b. ADDRESS<br><b>1300 Clark Ave</b>  |   |
| 22c. DATE SIGNED<br><b>12/16/58</b>   |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |   |
| 23b. DATE<br><b>12-19-1958</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood</b>   |   |
| 23d. LOCATION (City, town, or county)<br><b>St. Louis, Co.</b>  |   | 23e. STATE<br><b>Mo</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Jas H. Randle &amp; Son 3133 Bell Ave</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 17 '58</b>  |   |
| 26. REGISTRAR'S SIGNATURE<br><b>J. Earl Smith, M.D.</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>J.P.</b>   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Esther K. Harris*

Licensed Embalmer No. *4458*  
P. O. Address *418 1/2 Wash*

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.