

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003267  
STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **457**

300  
-57  
0  
22

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5148 Rosa Ave</b>		Length of stay in lb <b>45 yrs.</b>	d. STREET ADDRESS <b>5148 Rosa Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marshall Abraham Matson</b>			4. DATE OF DEATH Month Day Year <b>Jan. 13, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1890</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. ass't claim agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. RR</b>	11. BIRTHPLACE (City and state or county) <b>Frankford, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William Matson</b>		13b. MOTHER'S MAIDEN NAME <b>Emily Virginia Haden</b>		14. NAME OF HUSBAND OR WIFE <b>Elsie Matson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>702-14-0014</b>	17. INFORMANT Address <b>Mrs. Nina Smittle 5028 Christy Blvd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.		DUE TO (b) <b>arteriosclerotic heart disease</b>			4.5 years.
		DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Myocardial infarction (old). Hypertension</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <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 Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>12-18-58</b> to <b>12/27/58</b> and last saw <sup>him</sup> <del>her</del> alive on <b>12-27-58</b> Death occurred at <b>January 13, 1959 12:25</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>R. C. Treimon, M.D.</b> (Degree or title)			22b. ADDRESS <b>Hospital - R. C. Treimon</b>		22c. DATE SIGNED <b>1-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kirkwood, Missouri</b> (State)	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blv</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 14 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Robert C. Treiman  
Mo. Pacific Hosp.  
1755 So. Grand Blvd  
10 A.M.

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 *Joseph E. McCulloch* .....

Licensed Embalmer No. *2760* .....

P. O. Address *61758 Del* .....

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.

7