

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022708

FILED JUL 1 1959

Registration District No. Primary Registration District No.

STATE FILE NO. 2 5772
Registr. No.

300
-57

940

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|---|--|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital | | Length of stay in lb 10yr 3mo 21dys | | d. STREET ADDRESS (If outside, give location) 2413a S. 11th. St. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mattie Boing | | | | 4. DATE OF DEATH Month Day Year June 16, 1959 | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 31 1881 | | |
| | | | | 9. AGE (In years last birthday) 77 | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13a. FATHER'S NAME John Smith | | | 13b. MOTHER'S MAIDEN NAME Rebecca | | | 14. NAME OF HUSBAND OR WIFE JOHN BOING (DEC'D) | | |
| 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. None | | 17. INFORMANT ADELINE MARTIN 2628 TAMM Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>A. S. H. D.</i> | | | | | | | <i>10 yrs.</i> | |
| DUE TO (c) <i>Generalized Arteriosclerosis 4200F</i> | | | | | | | <i>10 yrs.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Intertrochanteric Fracture Left Femur - 5mo.</i> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>Patient fell out of bed on Dec. 12 of</i> | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year <i>2:45 a.m. 1/13/59</i> | | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>St. Louis Chronic Hosp., 5800 Arsenal.</i> | | | | | |
| 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>Feb. 25, 1949</i> to <i>June 16, 1959</i> and last saw her alive on <i>June 16, 1959</i> Death occurred at <i>4:55 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i> | | | | 22b. ADDRESS <i>5800 Arsenal</i> | | 22c. DATE SIGNED <i>6/17/59</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE <i>JUNE 18 1958</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>NEW PICKER CEM</i> | | 23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS MO.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Thomas Kates 1906 Greaves</i> | | | 25. DATE RECD. BY LOCAL REG. <i>JUN 17 '59</i> | | 26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i> | | | |

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 Eleanora Province

Licensed Embalmer No. 3403
P. O. Address Spring

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.