

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026935

FILED VS JUL 24 1959

2 6560

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6305 Idaho</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6305 Idaho</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Gustave E Mattern</u> | | | 4. DATE OF DEATH Month Day Year <u>7 10 1959</u> | | | |
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|-----------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|----------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/30/1880</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-----------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Germany</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Unk Mattern</u> | 13b. MOTHER'S MAIDEN NAME <u>Unk</u> | 14. NAME OF HUSBAND OR WIFE <u>Christine</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>493-01-3286</u> | 17. INFORMANT Address <u>Christine Mattern 6305 Idaho.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>422.1</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 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 |
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 1045 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Gabriel J. Taylor Carraway</u> | 22b. ADDRESS <u>1300 Clark</u> | 22c. DATE SIGNED <u>7.13.59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7-13-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Cemetary</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home. 6322 S. Grand Blvd.</u> | 25. DATE RECD. BY LOCAL REG. <u>JUL 13 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> m9B |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

David Van Pasow

Licensed Embalmer No. 4242

P. O. Address Jr Louis St

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.