RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

2 7612 59-030229

STATE FILE NUMBER

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

DED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2615 Rutger St., — Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 2615 Rutger St., — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Mattie	Middle:	Last: Bardwell	4. DATE OF DEATH	Month: Aug. Day: 14, Year: 1959
5. SEX: Female	6. COLOR OR RACE: Negro	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 1-7-1901	9. AGE (last birthday): 58	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (City and state or country): LaRange, Tennessee	12. CITIZEN OF WHAT COUNTRY: USA		
13a. FATHER'S NAME: Perry Maxwell	13b. MOTHER'S MAIDEN NAME: Dinia Wallace	14. NAME OF HUSBAND OR WIFE: —			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Mary Maxwell	Address: 2615 Rutger St.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Apoplexy

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 334X

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 315 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul J. Simon	(Degree or title) County Coroner	22b. ADDRESS: 1300 Clark	22c. DATE SIGNED: 8/17/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 8-21-59	23c. NAME OF CEMETERY OR CREMATORY: National Cemetery	23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR: G. Wade Granberry	ADDRESS: 4202 Finney Ave.	25. DATE RECD. BY LOCAL REG.: AUG 17 '59	26. REGISTRAR'S SIGNATURE: Karl Smith, M.D. (HT)

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Edward C. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.