

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-030615**

FILED VS SEP 4 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7773** STATE FILE NUMBER

|   |   |   |  |   |   |  |   |  |
|---|---|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Length of stay in 1b<br><b>2 days</b>   |  | c. CITY OR TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>4545a Adelaide Avenue</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>E</b> Last <b>McNatt</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>21</b> Year <b>1959</b>  |   |  |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12-29-1894</b>   | 9. AGE (last birthday)<br><b>64</b>   | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Maintenance</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Continental Can Co</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |   |  |
| 13a. FATHER'S NAME<br><b>William McNatt</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Phoebe Thilow</b>                                    |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Letha McNatt</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>499-28-9420</b>   |  | 17. INFORMANT Address<br><b>Mrs. Letha McNatt, 4545a Adelaide Av</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>Myocardial Infarction</b><br>DUE TO (b) <b>Coronary Sclerosis</b><br>DUE TO (c) <b>420.1</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b>                                    |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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.)  |  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>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   |   |  |
| 21. I attended the deceased from <b>July 20, 1959</b> to <b>Aug 21st</b> and last saw her/him alive on <b>Aug 20<sup>th</sup> 1959</b><br>Death occurred at <b>6:15 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |   |   |  |   |  |
| 22a. SIGNATURE<br><b>J.B. Jordan M.D.</b> (Degree or title)   |   |   | 22b. ADDRESS<br><b>5391 Grand Bl. St. Louis</b>                                      |   |   | 22c. DATE SIGNED<br><b>8/21/59</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal via Motor</b>   | 23b. DATE<br><b>8-22-1959</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakland Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Moberly, Missouri</b>   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b> ADDRESS  |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 21 1959</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith. M.D.</b>   |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

**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 *[Handwritten Signature]*

Licensed Embalmer No. 372

P. O. Address St. Louis

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.