URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–034730

STATE FILE NUMBER

FILED OCT 13 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2587

AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Anns
Length of stay in 1b: 20 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 11108 Ivan Ave.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clay
c. CITY OR TOWN: Excelsior Springs
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 402 E. Broadway
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Clara Middle: Last: Mattivi
4. DATE OF DEATH: Month: September Day: 29, Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 2/2/1890
9. AGE (last birthday): 69
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Terol, Italy
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Joseph Mattivi
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.: None
17. INFORMANT: Emma Foley, Address: 11108 Ivan Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unknown Natural Causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
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 10:30P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John C. Murphy M.D. John C. Murphy M.D., Asst. Health Commissioner
22b. ADDRESS: 801. S. Brentwood Clayton, Mo.
22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-2-59
23c. NAME OF CEMETERY OR CREMATORY: Crown Hill Cemetery
23d. LOCATION (City, town, or county) (State): Excelsior Springs, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc. ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: 9-30-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

~~on by~~ _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed *Lawrence O. Berling*

Signature of Student Embalmer

Licensed Embalmer No. *4779*

P. O. Address *St. Louis*

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