

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

'59 0 4 5 7 2 0

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211575**

ENDED

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) OR TOWN St. Louis		Length of stay in 1b		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 Lutheran Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3676a Arsenal St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First LEO Middle EUGENE Last MATTLER				4. DATE OF DEATH Month Dec. Day 11 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-11-1897		9. AGE (last birthday) 62		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installer (Retired) Western Electric Co.				10b. KIND OF BUSINESS OR INDUSTRY Alsace, Lorraine		11. BIRTHPLACE (City and state or country) U.S.A.				12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME Leon. E. Mattler				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Katie Olinda Mattler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. 498-09-2696		17. INFORMANT Address Katie O. Mattler 3676a Arsenal St.							
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 Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 11 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										331x			
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					
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.)									
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					
21. I attended the deceased from 12-2-59 to 12-11-59 and last saw him live on 12-11-59 Death occurred at 6:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE William W Farley M.D. (Degree or title)				22b. ADDRESS 3108 S. Grand				22c. DATE SIGNED 12-12-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 15, 1959		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park				23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.					
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway				25. DATE RECD. BY LOCAL REG. DEC 14 1959		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.							

DOCUMENT

MEDICAL CERTIFICATION

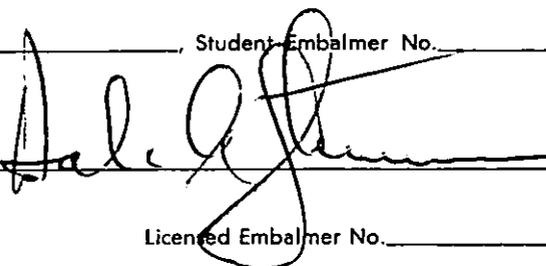
BY AFFIDAVIT OF

mjr

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  _____
Licensed Embalmer No. _____

P. O. Address _____

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.