

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS FEB 5 1960

-60-003794
 STATE FILE NUMBER

2 759
 Registrar No.

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		c. CITY OR TOWN <u>ST LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>		d. STREET ADDRESS (If outside, give location) <u>2110 SO. 11th ST.</u>	

3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>L</u> Last <u>MATHIS</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>19,</u> Year <u>1960</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>OCT. 15 1900</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>INDIANA</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
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13a. FATHER'S NAME <u>RALPH MATHIS</u>	13b. MOTHER'S MAIDEN NAME <u>MARY LAWLIS</u>	14. NAME OF HUSBAND OR WIFE <u>JODIE MATHIS</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>351-10-1974</u>	17. INFORMANT <u>JODIE MATHIS</u>	Address <u>2110 SO. 11th ST</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Bilateral Bronchopneumonia</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Cerebrovascular accident</u>	
DUE TO (b)	<u>advanced Cerebral arteriosclerosis</u>	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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 <u>1/3/60</u> to <u>1/19/60</u> and last saw her/him alive on <u>1/19/60</u> Death occurred at <u>4:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert K. Lane M.D.</u> (D, free or title)	22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>1/20/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>JAN 22 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MISSOURI CREMATORY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>	(State) <u>MO</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Grannis</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 22 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>
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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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906

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