URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008652

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1629 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 5 months

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Little Sistersof the Poor — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY

c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 5801 Park Lane. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MATHILDA Middle Last MUDD

4. DATE OF DEATH: Month Feb. Day 9 Year 1960

5. SEX: Female

6. COLOR OR RACE: white

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH:

9. AGE (last birthday): 89 — 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): housework

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (City and state or country): Red Bud Ill.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Not Known

13b. MOTHER'S MAIDEN NAME: Not Known

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.: none

17. INFORMANT: Address: Ely Wellhoener 5801 Park Lane

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): Arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: ? ? ?

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

DUE TO (b): 420.0

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): None

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 ☐ None

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 May 12, 1959, to Feb 9, 1960 and last saw her alive on Feb 7, 1960

Death occurred at 7 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Bernard H Flotte M.D.

22b. ADDRESS: 2435 N. Grand Blvd

22c. DATE SIGNED: 2-10-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: 2/12/1960

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS: Buchholz Mortuary 5967 W. Florissant

25. DATE RECD. BY LOCAL REG.: FEB 11 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. MDC

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 455

P. O. Address _____

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.