MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-012974

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2812

MAR 26 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 210
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Mo
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo
Length of stay in Ib: 9-Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 3225 N.Florissant Ave
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: St Louis Mo
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 3225 N.Florissant Ave
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Victoria Middle: Last: Mathais is

4. DATE OF DEATH: Month 3 Day 11 Year 62

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed X Divorced ☐
8. DATE OF BIRTH: 11-25-1876
9. AGE (last birthday): 85
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): House keeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Robert Dernier
13b. MOTHER'S MAIDEN NAME: Catherine Molloy
14. NAME OF HUSBAND OR WIFE: William

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Sister Albert Address: 3225 N.Florissant Ave

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):
DUE TO (c): 420-0

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 X
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 May 12, 1960 to March 3, 1962 and last saw her alive on March 9, 1962
Death occurred at 10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Bernard H. Hotte M.D. (Degree or Title)
22b. ADDRESS: 2435 N. Grand Blvd
22c. DATE SIGNED: 3-12-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-14-1962
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St Louis Mo

24. FUNERAL DIRECTOR: Arthur J. Donnelly ADDRESS: 3840 Lindell Blvd
25. DATE RECD. BY LOCAL REG.: MAR 13 1962
26. REGISTRAR'S SIGNATURE: Hoad Smith, M.D.

Dr B.H.Flotte

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4699

P. O. Address 384 Chinchilla

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.