

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

9760-62-040511

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. _____ Registrar's No. _____

FILED OCT 19 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | | |
|---|------------------|---|---|---|------------------|---|--|---------------------------------------|------------------|---|----------------|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 78 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis | | c. CITY OR TOWN Town + Country | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 12740 Post Oak Rd | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED. (Type or print) | | | First | Middle | | Last | 4. DATE OF DEATH | | Month | Day | Year |
| | | | LEON | Henri | | MATTHEY, Sr. | OCTOBER | | 10 | 1962 | |
| 5. SEX | 6. COLOR OR RACE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR |
| M | W | | | | 7-23-1880 | | 82 | | Months | | Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | | | | | |
| Retired President | | City Towel Co. | | Geneva Switzerland | | USA | | | | (Nat) | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | | | | |
| LOUIS MATTHEY | | | | Caroline (?) | | Elizabeth H. MATTHEY | | | | | |
| 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. | | 17. INFORMANT | | Address | | | |
| No | | | | | | Mrs Carol Miner, #8 Highland Pl. | | | | | |
| 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) CARCINOMA OF RIGHT LUNG | | | | | | | | | | 6 MONTHS | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO (b) _____ | | | | | | | | | | | |
| DUE TO (c) _____ | | | | | | | | | | | |
| 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. | |
| PULMONARY THROMBOSIS, LEFT | | | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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 | 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 | | | |
| | | | | | | | | | | | |
| 21. I attended the deceased from SEPT. 28, 1962 to OCT. 10, 1962 and last saw her/him alive on OCT. 10, 1962 | | | | | | | | | | | |
| Death occurred at 4:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | |
| <i>[Signature]</i> | | | | | | BARNES HOSPITAL | | | 10/11/62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | | | |
| Removal | | 10-11-62 | | Oak Grove Crematory | | St Louis County, Mo. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | |
| Alexander & Sons | | | | 6175 De' more Blvd | | OCT 11 1962 | | <i>[Signature]</i> | | | |

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 No Embalming, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Alexander J. Son Jnr
By Robert J. McQuillan
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.