

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026168

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6375** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <del>ST. LOUIS</del>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>GRANITE CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DE PAUL HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4005 VESCI AVENUE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>EVANS</u> Last <u>MATHIS</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1963</u>
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>9-3-1914</u>
9. AGE (last birthday) <u>48</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND REAL ESTATE</u>	11. BIRTHPLACE (City and state or country) <u>GRANITE CITY, ILL. U.S.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13. FATHER'S NAME <u>THOMAS QUINCY MATHIS</u>	
14. MOTHER'S MAIDEN NAME <u>CORA STEVENS</u>		15. NAME OF HUSBAND OR WIFE <u>ANGIE MATHIS</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W. II.</u>		17. INFORMANT <u>ANGIE MATHIS</u> Address <u>4005 VESCI AVE. GRANITE CITY, ILL.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO (b) <u>metastatic Carcinoma to Liver</u> DUE TO (c) <u>primary colon cancer</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>153.8</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 year</u> <u>1 year</u>
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.)	
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 <u>August 62</u> to <u>June '63</u> and last saw him alive on <u>14 June 1963</u> Death occurred at <u>1:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles C. Auld M.D.</u>		22b. ADDRESS <u>4511 Forest Park</u>	22c. DATE SIGNED <u>15 June</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-14-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET HILL</u>	23d. LOCATION (City, town, or county) <u>EDWARDSVILLE, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>ED MERCER SONS, GRANITE CITY, ILL.</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 17 1963</u>	26. REGISTRAR'S SIGNATURE <u>Ed Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles E. Mercer

Licensed Embalmer No. 2988

P. O. Address Shawnee City, Ill.

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.