

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041785

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10625 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF DOCUMENT

1
2 81257
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4 0
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11 812
12 52-0
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USE BLACK INK OR TYPEWRITER RIBBON

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN		d. STREET ADDRESS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		d. STREET ADDRESS		e. STATE		f. COUNTY		g. CITY OR TOWN		h. RESIDE ON FARM			
		ST. LOUIS, MISSOURI				Vienna				Illinois		Johnson		Vienna						Illinois		Johnson		Vienna		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>																						Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)						First Middle Last						4. DATE OF DEATH															
MARSHALL						C. MATHIS						10-23-63															
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR															
Male		White				2/8/1915		48		Months		Days		Hours		Min.											
10a. MALE 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															
Timberman				Timber				Johnson Co., Ill.				U.S.															
13a. FATHER'S NAME						13b. MOTHER'S MAIDEN NAME						14. NAME OF HUSBAND OR WIFE															
A.F. Mathis						Sarah H. Westman						Hazel Mathis															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.						17. INFORMANT Address															
No												Hazel Mathis, Vienna, Ill.															
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH															
IMMEDIATE CAUSE (a) CEREBRAL CONTUSION AND SUBDURAL HEMATOMA												18 hours															
TREE FALLING ON HEAD																											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																											
DUE TO (b)																											
DUE TO (c)												910-1-03															
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.															
												<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.)																			
		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		See #18, Pt. 1 (b)																			
20c. TIME OF INJURY		Hour a.m. p.m.		Month, Day, Year																							
				10-21-63																							
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											
				farm (home)				Vienna				Johnson				Illinois											
21. I attended the deceased from Oct. 21, 1963 to Oct. 23, 1963 and last saw her alive on Oct. 23, 1963																											
Death occurred at 4:20 PM 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															
FR. Phalley MD						BARNES HOSPITAL						10-24-63															
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)															
Removal			10-26-63			Fraternal Cemetery			Vienna, Ill.																		
24. FUNERAL DIRECTOR ADDRESS						DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE															
Mount Funeral Home, Vienna, Ill.						OCT 25 1963						Loal Smith. M.D.															

STATE OF MISSOURI

DEPARTMENT OF HEALTH

HEALTH DIVISION

ST. LOUIS

NO. 10-10-01

PROCESSED BY

60-02-01

HEALTH DIVISION

ST. LOUIS

6114

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SECTION 85

STATEMENT BY LICENSED EMBALMER

STATEMENT BY LICENSED EMBALMER

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2-27

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 Elton R. Remelius

Licensed Embalmer No. 4283

60-10-01

60-10-01

60-10-01

P. O. Address St. Louis, Mo.

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.

60-10-01

MISSOURI STATE BOARD OF HEALTH