

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

30910

7973

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since June 22, 1939
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Matthew House 200

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex M

5. Color or
race C

6. (a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife
Georgia House

6. (c) Age of husband or wife if
alive 55 years

7. Birth date of deceased June 15, 1883
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

56

2

27

hr. min.

9. Birthplace

Nashville

Tennessee

(City, town, or county)

(State or foreign country)

10. Usual occupation

nil

11. Industry or business

MOTHER FATHER

12. Name Aron House

13. Birthplace Nashville

Tenn

(City, town, or county)

(State or foreign country)

14. Maiden name Millie Jordan

15. Birthplace Carter Creek

Tenn

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature Sadie Goree

(b) Address 3427 Walnut St

17. (a) Burial (b) Date thereof Sept 17th
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle & Son

(b) Address 3133 Bell Avenue

19. (a) 9-14-39 (b) J. P. Randle
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3222 Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16th
year 1939 hour 9 minute 20 p. M.

21. I hereby certify that I attended the deceased from 6/22/39
_____, 19____, to 9/12/39, 19____;

that I last saw him alive on 9/12/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Arteriosclerosis with hypertension 10-12 yrs

Due to _____

Due to _____

Other conditions Hypertensive encephalopathy 2 mo.
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature H. J. Lyman (M. D. or other) _____

Address 2601 N. Whittier Date signed 9/14/39

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

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 this body is not embalmed, above space should be left blank.