

24217

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 6490

Registration District No. **201**
1003

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution: Homer Phillips Hospital

(d) Length of stay: In hospital or institution May 10, 1939

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis

(d) Street No. 1519 Carr

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mattie Cauley 400

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 8, 1880

8. AGE: Years 58 Months 8 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Georgia

10. Usual occupation nil

11. Industry or business _____

12. Name Dave Ivory

13. Birthplace unknown

14. Maiden name Mary

15. Birthplace unknown

16. (a) Informant's own signature Mary Wade

(b) Address 1519 Carr St

17. (a) Burial (b) Date thereof 7-24-39

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 Finney

19. (a) JUL 24 1939 (b) J. B. ...

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1939 hour 5 minute 50 a. M.

21. I hereby certify that I attended the deceased from May 10, 1939 to July 16, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease 10-12 yrs

Due to --

Due to --

Other conditions Senile psychosis; old cerebral accident unknown

Major findings: Of operations

Of autopsy _____

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? _____

(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 J. B. ... (M. D. or other) _____

Address 2601 ... Date signed 7-18-39

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

WAXED, PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *J. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 choir*

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.