

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3136

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: 3156 Evans Ave  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 4 yrs

3. (a) PRINT FULL NAME Mattie Fox

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

4. Sex Female  
5. Color or race Colored  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Isaac Fox  
6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years About 53  
Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. min.

9. Birthplace Dublin Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business John Atkins

12. Name \_\_\_\_\_  
13. Birthplace Dublin Miss.  
14. Maiden name Roma Thomas  
15. Birthplace Dublin Miss.

16. (a) Informant Isiah Fox

(b) Address 3156 Evans

17. (a) Washington Park (b) Date thereof April 17th 1940

(c) Place: burial or cremation A. L. Beal Und Co.

18. (a) Signature of funeral director 2726 Lucas Ave.

(b) Address \_\_\_\_\_

19. (a) APR 4 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State St Louis, Mo. (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(d) Street No. 3156 Evans Ave.  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 - 1940  
year \_\_\_\_\_ hour 12:30 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3-19 1940 to 4-1 1940  
that I last saw her alive on 3-30 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial weakness  
due to acute pleurisy caused  
by chronic bronchitis  
probably caused by  
chronic myocarditis.

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 Robert M. Scott D. or other \_\_\_\_\_  
Address 28390 Dickson Date signed 4-4-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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

*Burdie B. Anderson*

Licensed Embalmer No.

*2929*

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.**