

No. 2
2-45
17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6681

FILED FEB 17 1947
Registration District No. 318

Primary Registration District No. 1003

State File No. _____
Registrar's No. 1314

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 G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days
(Specify whether
In this community 3 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aaa
(c) City or town St. Louis 2/17
(If outside city or town limits, write "RURAL")
(d) Street No. 3116a Bell 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Winston Mathews

3. (b) If veteran, name war _____ 3. (c) Social Security No. 432-38-3966

4. Sex Male 2 5. Color or race col
6. (a) Single, widowed, married, divorced single 0

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

7. Birth date of deceased Aug 4th 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 6 2 hr. min.

9. Birthplace M^cNeal Ark 1
(City, town, or county) (State or foreign country)

10. Usual occupation Wood Seller

11. Industry or business _____

MOTHER FATHER

12. Name Brand Mathews

13. Birthplace Calhoun Co Ark 1
(City, town, or county) (State or foreign country)

14. Maiden name Julia Cross

15. Birthplace M^cNeal Ark 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Powell

(b) Address 3016a Bell ave

17. (a) Removal (b) Date thereof 2-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fordyce Dist (Ema Cemetery)

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

(b) Address 3133 Bell ave

19. (a) FEB 8 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6
year 1947 hour 12 minute 55 P. M.

21. I hereby certify that I attended the deceased from 1-10, 1947 to Feb. 6, 1947
that I last saw him alive on Feb. 6, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Broncho-pneumonia Undet.

Due to _____

Due to _____

Other conditions Lymphatic Leukemia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Yes

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 0

23. Signature E. L. Williams (M. D. or other) _____

Address 2601 N Whittier Date signed 2/17/47

WRITE 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.....

S. J. Watson

Licensed Embalmer No. *2698*

P. O. Address. *2769 Chouteau*

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, fact should be so stated above.