

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

7502

FILED MAR 11 1953

State File No.

318

1003

1908

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri				
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		2139		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital				d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal				
3. NAME OF DECEASED (Type or Print) a. (First) Matta b. (Middle) Morris c. (Last) Eddy			4. DATE OF DEATH (Month) (Day) (Year) 2 17 1953					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH 3-24-1868		9. AGE (In years last birthday) 84	10 UNDER 1 YEAR Months Days 10 23	11 UNDER 18 YRS. Hours Min. 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Mulford, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Washington Lafayette Morris		13b. MOTHER'S MAIDEN NAME Matilda Culp		14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Traub Baltimore Hotel				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardio-vascular disease 5 yrs. ANTECEDENT CAUSES Aborbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ABronchiectasis-chronic 2 yrs. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4221				
22. I hereby certify that I attended the deceased from 7-1-51, 19__, to 2-17-53, 19__, that I last saw the deceased alive on 2-17, 1953, and that death occurred at 7:40p m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Betty Harris Simon MD				23b. ADDRESS 5400 Arsenal Street		23c. DATE SIGNED 2-18-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 2-18-1953	24c. NAME OF CREMATOR Oak Grove		24d. LOCATION (City; town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL FEB 18 1953		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert J. Ambruster Inc 6633 Clayton Rd				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ernest W. Spillars

Licensed Embalmer No. 4080

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, fact should be so stated above.