

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6860

State File No.

BIRTH FILED MAR 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1359

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>	c. LENGTH OF STAY (in this place) <u>11 YRS.</u>	c. CITY OR TOWN <u>ST. LOUIS</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>2359 So. 39TH ST.</u>		e. STREET ADDRESS (If rural, give location) <u>17 2359 So. 39TH ST. 2173</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>-</u>	c. (Last) <u>MATTESON-STERLING</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 11TH 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR. 5TH 1876</u>	9. AGE (in years last birthday) <u>77 YRS.</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORMERLY-HOUSE-WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT-HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CHICAGO - ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES-R-DOOLITTLE</u>	13b. MOTHER'S MAIDEN NAME <u>CLARA-MATTESON</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN-K. STERLING (DECD.)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Paul Matteson</u>	ADDRESS <u>4637 Zionsboro Ave</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis general</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4201</u>
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22. I hereby certify that I attended the deceased from January 1954, to February 1954, that I last saw the deceased alive on Jan 11, 1954, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph W. Koch, M.D.</u>	(Degree or title)	23b. ADDRESS <u>607 N. Main St.</u>	23c. DATE SIGNED <u>2/12/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>FEB. 15TH 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA-CHAPEL OF MEMORIES</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS - COUNTY - MO.</u>
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DATE REC'D BY LOCAL REG. <u>FEB 13 1954</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>MO-Brockland Bur. Co.</u>	ADDRESS <u>1827-HOGAN-ST.</u>
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(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.....
Signature of Student Embalmer

Signed *John J. Haines*.....
Licensed Embalmer No. *4180*.....
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.