

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. **85861-60**

1. NAME OF DECEASED  
**RALPH MATTIS**  
 2. DATE AND HOUR OF DEATH  
**9-13-60 1:40 A.M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND  
**WILLIAMSPORT Hosp.  
 WILLIAMSPORT, PA**  
 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)  
 A. STATE **PA** B. COUNTY **NORTHUMBL'D**  
 C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
**RURAL DELA. TWP.**  
 D. STREET ADDRESS (If rural, give location)  
**DEWART**

5. SEX **M** 6. RACE **W** 7. MARRIAGE STATUS  
 NEVER MARRIED  WIDOWED  DIVORCED  8. DATE OF BIRTH  
**8-24-1890** 9. AGE in years (last birthday) **70**  
 If Under 1 Yr. Specify Days Hours Min. If Under 24 Hrs. Specify Hours Min.

10. OCCUPATION, BUSINESS OR INDUSTRY  
**RET. TRUCK DRIVER** 11. BIRTHPLACE (State or foreign country)  
**ROXHAM, PA** 12. CITIZEN OF WHAT COUNTRY?  
**USA**

13. MOTHER'S MAIDEN NAME  
**ANNIE KROM** 17. INFORMANT  
**MRS. JAMES WARREN, 419 MADISON AVE., FORT WASHINGTON, PA**

16. SOCIAL SECURITY NO.  
**—**

CAUSE OF DEATH  
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
**MYOCARDIAL INFARCTION**  
 INTERVAL BETWEEN ONSET AND DEATH  
**7 DAYS**

2937  
 DUE TO **2° ANEMIA AND CORONARY ARTERIOSCLEROSIS**  
 ANTECEDENT CAUSES  
 DUE TO **?**

18. PROBABLE REGIONAL ENTERITIS  
 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
**YES**

21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
 21C. HOW DID INJURY OCCUR?

21D. INJURY OCCURRED  
 While at Work  Not While at Work   
 21E. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE  
 M.D. Attending Phys.  Med. Director  Staff Phys.   
**9-18-60**

23C. PHYSICIAN'S NAME (If not)  
**STUART B. GIBSON / U. CATHERMAN M.D.** 23D. ADDRESS  
**WILLIAMSPORT, PA**

24. BURIAL CREMATION, 24B. DATE REMOVAL (Specify)  
**BURIAL- 9-16-60** 24C. NAME OF CEMETERY OR CREMATORY  
**VALLEY FORGE GARDENS** 24D. LOCATION (City, town, or county) (State)  
**KING OF PRUSSIA, PA.**

25A. DATE RECD BY HEALTH DEPT.  
**9-13-60** 25B. NAME OF REGISTRAR  
**ALFRED A. PARK** 25C. FUNERAL DIRECTOR  
**RICHARD C. ALLEN, W. MSP., PA.**