

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
13769
~~10000~~
File No. _____
Registered No. 65 St. _____ Ward _____

MAY 27 1930

PLACE OF DEATH
County St. Francois
Township St. Francois
City Near Farmington, Mo.

Registration District No. 773
Primary Registration District No. 6018A

2. FULL NAME Nancy Matkins
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25, 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
52 8 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Arcadia
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER J. L. Matkin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Arcadia
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Sarah Twitty Matkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Unknown

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 4-15-30 V. J. Robinson
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 1930

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1930 to April 14, 1930 that I last saw her alive on April 13, 1930 and that death occurred, on the date stated above, at 3:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of the Lungs.

CONTRIBUTORY (SECONDARY) Insanity
(duration) 5 yrs. _____ mos. _____ ds.

18. WHEN WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical.
(Signed) J. C. Tincher, M. D.
4/15/30 (Address) Farmington, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Arcadia Mo DATE OF BURIAL April 16 1930

20. UNDERTAKER H. R. White ADDRESS Monton, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

