

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.

AUG 13 1934

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

Do not use this space.

1. PLACE OF DEATH

County Folk
Township Green
City Goodson (No.)

Registration District No. 708
Primary Registration District No. 5937c

File No. 21515
Registered No. 11
St. Ward)

2. FULL NAME

Minnie Matthews
(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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-27-1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
40 7 12

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
None None

12. BIRTHPLACE (CITY OR TOWN) Ballast (STATE OR COUNTRY) Mo

FATHER 13. NAME Henry Ben

14. BIRTHPLACE (CITY OR TOWN) Iron (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Emma Morrison

16. BIRTHPLACE (CITY OR TOWN) Dallas (STATE OR COUNTRY) Mo

17. INFORMANT Paul Matthews (ADDRESS) Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Start DATE 6-3-34

19. UNDERTAKER W. J. ... (ADDRESS) Goodson

20. FILED 6-7-34 1934 W. J. ... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June - 2 - 34

22. I HEREBY CERTIFY, That I attended deceased from 5-30, 1934, to 6-2, 1934

I last saw her alive on 6-1-34, 1934. Death is said to have occurred on the date stated above, at 12 p.m.

The principal cause of death and related causes of importance were as follows:

Obstruction of bowels from adhesions by previous operator

Other contributory causes of importance:

Name of operation Date of
W. J. ...

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

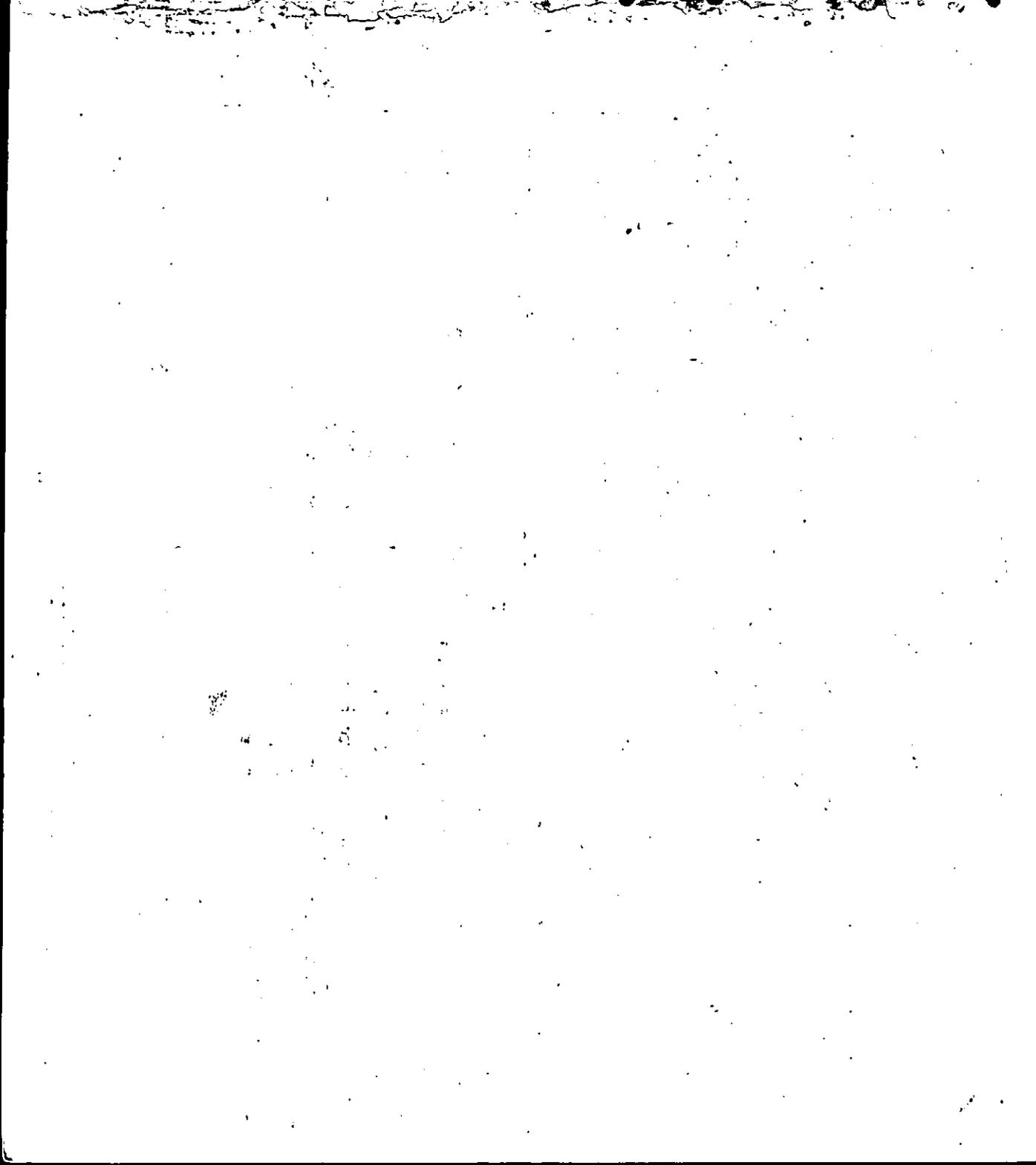
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) W. J. ..., M. D.

(Address) Lomburg, Mo



Pack

WASHINGTON

21515

11

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Minnie Mathews*

Who died at _____ on *June 2 - 1934*

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years *3* Months *1* Days *20*

Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth *11-22-1894* Age: Years *39* Months *5* Days *20*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Obstruction of bowels from adhesions by previous

Birthplace (State or country) *Adhesions by previous*

Birthplace of father (State or country) *Operative, Obstruction*

Birthplace of mother (State or country) *Was cured from adhesions*

Principal cause of death: *A previous operation at Springfield Mo. at St. John's Hospital, 1919 for Pso. Subcut. Abscess*
No postural cause

Other contributory causes of importance _____
Name of operation *Salpingitis* Date of *1929* *1929*

What test confirmed diagnosis? *Physical Exam* Was there an autopsy? *NO*

If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

Name of physician _____
Address of physician _____

Signature of Registrar *Mal Zumbalt*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *708* Very truly yours,
E. T. Mc Gaugh M.D.

Primary Reg. Dist. No. *5937C* *S.A.*
Special Agent.

S21515