

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

39227

Do not use this space.

DECEMBER 13 1938

**1. PLACE OF DEATH**

(a) County GREENE Registration District No. 316  
 (b) Township N. Campbell Primary Registration District No. 2001 Registered No. 910  
 (c) City SPRINGFIELD (d) Street No. 1129 N. Fremont St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 6 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** MATHEW HALE LOUGHEAD

(a) Residence, No. 1129 N. Fremont St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) Allie R. Montgomery

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
✓ 72 2 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

FATHER 13. NAME Joseph Loughead

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

MOTHER 15. MAIDEN NAME Susan Funsaber

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

17. INFORMANT (ADDRESS) Mrs Susan Loughead 1129 N. Fremont

18. BURIAL, CREMATION, OR REMOVAL PLACE East Lawn DATE 12-2 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wright-Hall 629 West Walnut

20. FILED Dec 2 1938 Chas. A. George Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1938

22. I HEREBY CERTIFY, That I attended deceased from 11, 25, 38 19, to 11, 30, 38 19.

I last saw him alive on 11, 29, 38 19. Death is said

to have occurred on the date stated above, at 7:15 A.M.

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

Hemorrhage, cerebral

Date of onset Don't know

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 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) J. J. J. J. \_\_\_\_\_, M. D.  
Springfield, Mo.

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

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*Ray L. W. Ford*

Licensed Embalmer No.....

*2910*

P. O. Address.....

*629 W Walnut*

**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, above space should be left blank.**