

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

42646
Do not use this space.

REC'D JAN 18 1939

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
 (b) Township Carroll Primary Registration District No. 3010
 (c) City Carrollton (d) Street No. _____ Registered No. 126
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 350 John T Matney 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 Maudie Best
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 26, 1858
 7. AGE YEARS 80 MONTHS 2 DAYS 23 If LESS than 1 day, _____ hrs. or _____ min.
 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) Indiana

FATHER 13. NAME Wm Matney

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

MOTHER 15. MAIDEN NAME Ruth Parks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (NAME) (ADDRESS) Mrs John Matney
Carrollton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Waller Cemetery DATE Dec 21 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton Mo

20. FILED 12-21-38 Ruth Haskin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 19 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-9 1938 to Dec 19 1938

I last saw him alive on Dec 19 1938 Death is said to have occurred on the date stated above, at 8:00 p.m.

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

Myocardial Insufficiency
131
 Date of onset 1 yr. ago

Other contributory causes of importance: Chronic Hepatitis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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? no
 If so, specify _____ (Signed) W. G. Atwood, M. D.

(Address) Carrollton, Mo

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.

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THE BOARD OF HEALTH OF THE DISTRICT OF COLUMBIA
OFFICE OF THE DISTRICT HEALTH OFFICER
1100 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20004

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6E/E/11

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,

Ben W Gibson

, or by

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

Signed

Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address *Carrollton, Md*

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.