

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.

350 MAR 16 1939

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

7003
Do not use this space.

1. PLACE OF DEATH

(a) County Lafayette
(b) Township Odessa
(c) City Odessa

Registration District No. 464
Primary Registration District No. 4277

Registered No. 9

(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 321 James W. Matthews St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 Mrs. Laura Adams Matthews

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 21, 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 2 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired 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) Victoria B. C.

FATHER 13. NAME Patrick Matthews

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

MOTHER 15. MAIDEN NAME Sarah Minor

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

17. INFORMANT (ADDRESS) John Matthews Odessa Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Odessa Cem. DATE 2/28 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. G. Lusman Odessa Mo.

20. FILED 2/27 1939 Mrs. E. M. Goodwin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/26 1939

22. I HEREBY CERTIFY that I attended deceased from Feb. 18 1939 to Feb. 25 1939. I last saw him alive on Feb. 25 1939. Death is said to have occurred on the date stated above, at 1:03 p. m.

The principal cause of death and related causes of importance were as follows:
Heart Pneumonia (acute) mitral insufficiency with failing compensation

Other contributory causes of importance:
Chronic Pulmonary T.

Name of operation J. J. Date of no
What test confirmed diagnosis clinical 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? _____
If so, specify _____
(Signed) R. C. Schuchman M. D.
Odessa Mo. (Address)

OFFICE OF THE DISTRICT HEALTH OFFICER

Date Filed 3/14/39
District No. Member
District Health Officer No. 8

RECEIVED

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

Licensed Embalmer No.

P. O. Address

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.

