

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECD APR 6 1939

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

11068
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 1 Registration District No. 398
 (b) Township Blue Primary Registration District No. 2554 Registered No. 108
 (c) City Independence (d) Street No. 2506 Vermont St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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. 2517 Vermont 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- <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Child</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mch-7-1929</u>				
7. AGE YEARS <u>10</u>		MONTHS <u>0</u>	DAYS <u>18</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>at school</u>			
	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) <u>Mounds Illinois</u>				
FATHER	13. NAME <u>John E. Mattson</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mounds Illinois</u>			
MOTHER	15. MAIDEN NAME <u>Una Smith</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kilmstead Illinois</u>			
17. INFORMANT (ADDRESS) <u>John E. Mattson 2517 Vermont</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Royal Hills Kansas City, Mo.</u> DATE <u>Mar. 28, 1939</u>				
19. FUNERAL DIRECTOR (ADDRESS) <u>George C. Carson Independence Mo.</u>				
20. FILED <u>3-30-39</u> <u>F. L. Cook</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mch. 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 19, 1939 to Mar 26, 1939
 I last saw her alive on Mar 20, 1939 Death is said to have occurred on the date stated above, at 10 P.M.
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset 3/12/39

Other contributory causes of importance:
(Brain) cerebella tumor 1/1/39

Name of operation none Date of no
 What test confirmed diagnosis? X-Ray 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) Fred W. Shank _____, M. D.
Farmer (Address) Mo

55A

THE REGISTERED EMBALMER

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
 hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
 _____ L. E. _____
 No. _____ or by _____, Registered Apprentice No. _____
 working under my personal supervision.

Signed _____
 _____ Licensed Embalmer No. _____

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.)

CIVIL SERVICE BOARD
M. H. EAGLE

7

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

11068
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 398
 (b) Township Blue Primary Registration District No. 5554 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Rosaline Mattoon
 (a) Residence, No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 0 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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)

FATHER 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
 I last saw h... alive on 19... Death is said to have occurred on the date stated above, at... m.
 The principal cause of death and related causes of importance were as follows:

Bacterial Pneumonia
5 ft 2'
 Other contributory causes of importance
(Brain) Cerebellar Tumor
Benign
 Date of onset

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) Fred W. Hensel M. D.
 (Address) Farmount mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

1947 - 7 1970