

REC'D JUN 14 1939

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

18109  
Do not use this space.

1. PLACE OF DEATH

(a) County DUNCANIAN Registration District No. 85  
 (b) Township Washington Primary Registration District No. 1001 Registered No. 553  
 (c) City St. Joseph (d) Street No. No. Methodist Hosp. 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. 326 FRANCES VIOLA MATHIAS St. Maysville Mo  
 (Equal 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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED  
 HUSBAND OF HAM MATHIAS  
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 2 - 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.  
63 4 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME  
 9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEWIFE  
 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) DEKALB Co. MO

FATHER 13. NAME JOHN RUSSELL MOORE 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME MARY L. SWEET 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT MRS. B.P. IDEN (ADDRESS) Maysville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE DEK. GRAVELEM. DATE 5/29 39

19. FUNERAL DIRECTOR (NAME) W.G. Packer (ADDRESS) Maysville Mo

20. FILED May 27, 1939 A.J. Kuttelbach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 27 1939

22. I HEREBY CERTIFY, That I attended deceased from May 17 39 to May 27 39  
 I last saw her alive on May 26 39 Death is said to have occurred on the date stated above, at 3:30 a.m.

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

Relapsing pneumonia  
hypostatic  
congestive heart failure  
 Date of onset May 12

Other contributory causes of importance:

Thrombosis of the cerebral vein  
hypertension  
chronic white's anemia  
 Date of onset May 8

Name of operation amputation Date of May 15 39

What test confirmed diagnosis Clinical Was there an autopsy? Yes

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) N. S. J. ... M. D.  
 (Address) St. Joseph 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.

**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 *[Signature]*

Licensed Embalmer No. *3960*

P. O. Address *Maple 76*

**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.**