DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS 133

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26154

Registration District No. 508 Primary Registration District No. 3615 Registrar's No.

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.

1. PLACE OF DEATH: 2

(a) County: Linn Co.

(b) City or town: Rural--Jefferson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 22 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County 1

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 22 years.

3. (a) PRINT FULL NAME Nels N. Matson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Blanche Buzan Matson

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 23, 1873 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	1	6	hr. min.

9. Birthplace Felking, (City, town, or county) Sweeden (State or foreign country)

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER

12. Name Nels N. Matson Sr.

13. Birthplace (City, town, or county) Sweeden (State or foreign country)

14. Maiden name Anna Marie Swanson

15. Birthplace (City, town, or county) Sweeden (State or foreign country)

16. (a) Informant's own signature Mrs. Ryall Hanson

(b) Address 1204 Clay, Chillicothe, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo.

18. (a) Signature of funeral director Mr. Sharne

(b) Address Laclede, Mo. 44

19. (a) July 30-1939 (Date received by local registrar) Geo O Plowman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1939 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb, 1939, to July, 1939, that I last saw him alive on July 28, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lateral Sclerosis	
Due to Chronic pyelonephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Wm F. La Marne (M. D. or other)

Address Laclede, Mo. Date signed 7/31/39

(Licensed Embalmer's Statement on Reverse Side)

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 Me

W.G.Thorne, Registered Apprentice No.

working under my personal supervision.

Signed W.G.Thorne

Licensed Embalmer No. 2876

P. O. Address W.G.Thorne

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.