

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

42832
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001
 (c) City St. Joseph (d) Street No. Mo. Meth. Hospital 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 320 EDGAR E. MATTOCKS

(a) Residence, No. Atchison Kansas St. Atchison, Kansas
 (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 Bessie Mattocks
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 8th. 1875
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 8 11
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Asst. Cashier
 9. Industry or business in which work was done, as saw mill, bank, etc. Exchange National Bank
 10. Date deceased last worked at this occupation (month and year) _____ Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 19th. 1939
 22. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1939 to Dec 29, 1939.
 I last saw him alive on Dec 19, 1939. Death is said to have occurred on the date stated above, at 11:30 PM
 The principal cause of death and related causes of importance were as follows:

Septicemia, Sepsis
1939
 Other contributory causes of importance:
Hypertrophy of Prostate

Date of onset

Names of operation Prostate resection Date of _____
 What test confirmed diagnosis? Urin 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) Charles Frenkel, M. D.
85 (Address) St. Joseph Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchison Kan.

FATHER 13. NAME E. E. Mattocks
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Penn.

MOTHER 15. MAIDEN NAME Mary Leddle
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Ind.

17. INFORMANT Wallace Mattocks
 (ADDRESS) Atchison Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Atchison Kan. DATE Dec. 19th. 1939

19. FUNERAL DIRECTOR (NAME) FLEEMAN & SON, INC.
 (ADDRESS) 1916 Calhoun St. Joseph, Mo.

20. FILED Dec 26 39 H. H. Hentle
Local Registrar

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..... *A. G. Swan*

Licensed Embalmer No. *4082*

P. O. Address *St. Joseph, Mo.*

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.