

60M-5-17-39
 REV. 5-17-39
 I X19311
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 MARGIN RESERVED FOR BINDING

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:
 (a) County Greene
 (b) City or town Springfield MO
 (c) Name of hospital or institution:
719 N. Campbell St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution V
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME JOHN LEONARD MATT
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sophia Matt 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 27 1862
 (Month) (Day) (Year)

8. AGE: Years 78 Months - Days 10 If less than one day hr. _____ min. _____

9. Birthplace Columbus Ohio
 (City, town, or county) (State or foreign country)
 10. Usual occupation Laborer

11. Industry or business _____
 12. Name John Matt 6
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Neumann
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sophia Matt
 (b) Address 719 N Campbell St
 17. (a) Burial (b) Date thereof 3-11-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Maple Park
 18. (a) Signature of funeral director Wynn
 (b) Address Springfield MO
 19. (a) 3/11/40 (b) Chas. A. Deary
 (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 719 N Campbell St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? USA years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 8
 year 1940 hour 3 minute 20 P.M.
 21. I hereby certify that I attended the deceased from _____, 19____, to Mar 8 1940
 that I last saw him alive on Mar 8 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 6 days
 Due to arterio-sclerosis
 Due to _____
 Other conditions (include pregnancy within 3 months of death) none

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? _____ (Specify type of place)
 23. Signature Arthur D. Mable (M. D. or other) MD
 Address 400 E. Court Date signed 3-9-40

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

Hoyd W. Fox

Licensed Embalmer No.

2910

P. O. Address

629 W Walnut

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.

X