DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUN 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19085

Registration District No. 274 — Primary Registration District No. 6261 — Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid Lincoln Twp

(b) City or town Catron — (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 ✓ (Specify whether years, months or days) 2

In this community ✓

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

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

(d) Street No. 0 (If rural, give location)

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

3. (a) PRINT FULL NAME Minnie Mathies 320.

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex F

5. Color or race C

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

6. (b) Name of husband or wife James Mathies

6. (c) Age of husband ~~or wife~~ if alive 44 years

7. Birth date of deceased 1912 (Month) Apr (Day) 12 (Year)

8. AGE: Years	Months	Days	If less than one day
28		16	hr. min.

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

10. Usual occupation At Home

11. Industry or business At Home

FATHER
12. Name Robert Gary
13. Birthplace Miss (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lurma James
15. Birthplace Miss (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

(b) Address Catron

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 29 40 (Month) (Day) (Year)

(c) Place: burial or cremation Poor Farm Cem. NM. Co

18. (a) Signature of funeral director

(b) Address 537

19. (a) Apr 29/40 (Date received local registrar) (b) E. E. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 28 year 1940 hour 11a minute M.

21. I hereby certify that I attended the deceased from 3/4 40, 19, to 4-28, 1940 that I last saw her alive on 4-10, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Aortic Regurgitation	
Due to	
Due to 92 W	
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 W J Hunt (M. D. or other)

Address Essex Date signed 4/29/40

(Licensed Embalmer's Statement on Reverse Side)

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.

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RECEIVED
District Health Officer No
District File Number 640-11
Date Filed 6/10/46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.