

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24282**
2892
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7/17/40 2-7/17/40
(Specify whether
In this community 2 days
years, months or days)

3. (a) PRINT FULL NAME Lloyd Charles Matthews **370**

3. (b) If veteran, No name war No
3. (c) Social Security No. No

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --
6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Sept. 3, 1920
(Month) (Day) (Year)

8. AGE: Years 19 Months 10 Days 6
If less than one day hr. min.

9. Birthplace Franklin Co., Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Baseball Pitcher

11. Industry or business

12. Name Berl Matthews

18. Birthplace Fulton Co., Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Olive Mills

15. Birthplace Franklin Co., Kans.
(City, town, or county) (State or foreign country)

16. (a) Informant Berl Matthews

(b) Address Rantone, Kansas

17. (a) Paula Kansas (b) Date thereof July 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Metzlers Funeral Home

(b) Address Paula Kansas

19. (a) July 18, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County
(c) City or town Rantone
(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. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19
year 40 hour 10:00 P. minute M.

21. I hereby certify that I attended the deceased from 7/17/40 to 7/17/40, 1940;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis of left heart
and myocardial infarction
(Coronary thrombosis)

Due to Coronary thrombosis
Due to (Coronary thrombosis)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

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

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 7/21/40

Where did injury occur? Paula, Kan.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway
While at work? (Specify type of place)
(e) Means of injury Motor Car

23. Signature [Signature] (M. B. or other)
Address Keou Date signed 7/19/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

6/17/20
98

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____
Registrar's No. 2892-

Registration District No. _____ Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson Mo.

(b) City or town _____
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Cloyd E. Matthews

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 A

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____ (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 7/19/46 (b) M. M. Brown

(Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(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.? _____ years.

20. DATE OF DEATH: Month July Day 19 Year 40

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Auto transportation

Due to _____

Due to Car overturned

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 210 / 8

Of autopsy _____

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

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

(b) Date of occurrence 7-17-40

(c) Where did injury occur? Paula K. (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway No 2

While at work? _____ (Specify type of place) Motor car (e) Means of injury

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

5-24282