

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 19 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28511

State File No.

666

Registrar's No.

Registration District No. 316

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution:
1320 Cario, Springfield, Mo. 2
(d) Length of stay: In hospital or institution Several Years
In this community Several Years

3. (a) PRINT FULL NAME Alpha Van Matre 536

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Alfred T. Van Matre 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Sept 30 1888
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 13 If less than one day hr. min.

9. Birthplace Mc.Causland, Ia. Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm.H. Smothers

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

14. Maiden name Marry Ann Mound

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

16. (a) Informant Alfred T. Van Matre

(b) Address 1320 Cario, Springfield, Mo.

17. (a) Burial (b) Date thereof Aug. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

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

(b) Address Springfield, Mo.

19. (a) 9-15-40 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield, Mo.
(d) Street No. 1320 Cario
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13th.
year 1940 hour 10:30 minute A.M.

21. I hereby certify that I attended the deceased from Aug 13
1940 to Aug 15 1940
that I last saw her alive on Aug 15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage

Due to right blood vessel

Other conditions (include pregnancy within 3 months of death) g2h

Major findings: Of operations no
Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

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

(e) While at work? no (Specify type of place) (f) Means of injury no
Signature W. E. Handley (M. D. or other)
Address Springfield Date signed

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

MOTHER FATHER

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. Ford

Licensed Embalmer No.

2910

P. O. Address

679 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, fact should be so stated above.

X