

Registration District No. 124

Primary Registration District No. 5199

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Cape Girardeau County, Mo.
 (b) City or town Boonville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution County Home (Boonville)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 yr. (Specify whether years, months or days)
 In this community 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Boonville
 (If outside city or town limits, write "RURAL")
 (d) Street No. Boonville, Mo. (Rural)
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Anna B. Mathers

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Unmarried
 6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Don't know
 (Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Don't know

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

14. Maiden name Don't know

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

16. (a) Informant's own signature Buenalright

(b) Address Cape Girardeau Mo

17. (a) Burial (b) Date thereof 12-22-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Pleasant

18. (a) Signature of funeral director James H. Huber

(b) Address Cape Girardeau Mo

19. (a) 12-22-40 (b) D. G. Huber
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 40 hour 10 minute 10 M.

21. I hereby certify that I attended the deceased from July 10 1940 until Dec 20 1940
 that I last saw her alive on Dec 17 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death High Blood Pressure
 Due to other diseases

Duration

1 yr

Other conditions (Include pregnancy within 3 months of death) 91

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? _____

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

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

Address [Address] Date signed [Date]

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.....

W. H. Estes....., Registered Apprentice No.....
working under my personal supervision.

Signed W. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau
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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42067
Registrar's No. 47

Registration District No. 124

Primary Registration District No. 5179

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Byrd Twp
(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 _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Anna B Mathers

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 85 Months 8 Days 21 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-22-40 (Date received local registrar) (b) A. G. Seibert (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9 year 1946 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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? _____

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

23. Signature G. P. Schaen (M. D. or other) _____

Address Jackson _____ signed

SUPPLEMENTAL

WPA FIELD

1940

S-42067