

FD JAN 23 1941

Registration District No. **816**

Primary Registration District No. **4492**

Registrar's No. **40**

1. PLACE OF DEATH:
 (a) County Scott Chaffee, Mo
 (b) City or town _____
 (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 _____
 In this community all his life (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME: SYLVESTER, MATTHEWS
3. (b) If veteran, name war: no
3. (c) Social Security No: 498-07-9139

4. Sex: Male **5. Color or race:** White **6. (a) Single, widowed, married, divorced:** Married
6. (b) Name of husband or wife: Elyzabeth Matthews **6. (c) Age of husband or wife if alive:** 52 years
7. Birth date of deceased: 7-17-1881 (Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace: Scott Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: M. P. G. **11. Industry or business:** Palmer

MOTHER FATHER
12. Name: John Matthews
13. Birthplace: No record Penn (City, town, or county) (State or foreign country)
14. Maiden name: Frances Owens
15. Birthplace: Scott Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Elyzabeth Matthews
(b) Address: Chaffee Mo.

17. (a) Date of death: 12-29-1940 (Month) (Day) (Year)
(b) Date thereof: 12-29-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Trinity Park, One Chaffee

18. (a) Signature of funeral director: Stubbs
(b) Address: Chaffee Mo
19. (a) Date received local registrar: 12/31/1940 (b) (Registrar's signature) _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Scott
 (c) City or town Chaffee (If outside city or town limits, write "RURAL")
 (d) Street No. 310 Davidson Ave (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 26 year 1940 hour 3 minute 50 AM.
21. I hereby certify that I attended the deceased from: April 1st, 1940 to Dec 26, 1940
 that I last saw him/her live on Dec 25, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Stomach **Duration:** 1 yr

Due to: _____
Due to: 4/6

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? 735 (Specify type of place) _____ (e) Means of injury _____

23. Signature: W. Sample (M. D. or other) _____
Address: Chaffee Mo. **Date signed:** 12-30-1940

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

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.

RECEIVED

District Health Officer No. 2,

District File Number 141-1

Date Filed 1-2-41

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.