

Registration District No. **774**

Primary Registration District No. **4465**

Registrar's No. **1020**

94
5
2

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

1. PLACE OF DEATH:
 (a) County St. Francois
 (b) City or town Flat River
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(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 Dacey Mathew
3. (c) Social Security _____
3. (b) If veteran, _____ **name war** _____ **No.** _____

4. Sex M **5. Color or** W **6. (a) Single, widowed, married,** _____
race divorced
6. (b) Name of husband or wife Monroe Mathew **6. (c) Age of husband or wife if** _____
alive _____ years
7. Birth date of deceased July - 27 - 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 20 If less than one day _____
hr. min.

9. Birthplace Iron Mountain, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business at home

MOTHER FATHER
12. Name William Brown
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Langley
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Alex Brown
(b) Address Knoblich Rt 1

17. (a) Burial local cemetery **(b) Date thereof** 2-19-41
(Burial, cremation, or removal) (City or town) (County) (State)
(c) Place: burial or cremation local cemetery

18. (a) Signature of funeral director Galdwell Bros
(b) Address Flat River Mo

19. (a) 2-26-41 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Francois
 (c) City or town Flat River 94
(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.? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 17
 year 1941 hour 6 minute A M.
21. I hereby certify that I attended the deceased from Nov. 11
1939, to Feb 17, 1941;
 that I last saw h^{er} alive on 2-14, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chr myocarditis
 Duration _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
PHYSICIAN
 Major findings: _____
Of operations
 Of autopsy _____
 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?
697 (Specify type of place)
 While at work? _____ (e) Means of injury _____
23. Signature [Signature] (M. D. or other) MD
 Address Flat River Mo Date signed 2-17-41

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.