

FILLED NOV 14 1941

Registration District No. 228

Primary Registration District No. 3017

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County Grundy
- (b) City or town Neuton (If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: 418 E 18th (If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)
- In this community all life years, months or days

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Grundy
- (c) City or town Neuton (If outside city or town limits, write "RURAL") 040
- (d) Street No. 418 E 18th (If rural, give location) 1
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

## 3. (a) PRINT FULL NAME

WILLA LENE MATEK3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. none

4. Sex 71 5. Color or race w 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased sept 8 1939  
(Month) (Day) (Year)8. AGE: Years 2 Months 17 Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Bermsan mo  
(City, town, or county) (State or foreign country)10. Usual occupation child

11. Industry or business \_\_\_\_\_

12. Name was a m<sup>o</sup> atec13. Birthplace mo  
(City, town, or county) (State or foreign country)14. Maiden name Lula Hays15. Birthplace mo  
(City, town, or county) (State or foreign country)16. (a) Informant was a. m<sup>o</sup> atec(b) Address 418 E 18 Neuton17. (a) Burial (b) Date thereof oct 12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Willis Chappell18. (a) Signature of funeral director W. J. Gannon(b) Address Neuton mo19. (a) 10-9-41 (b) J. W. Fair  
(Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month oct day 9  
year 1941 hour 12 minute 5021. I hereby certify that I attended the deceased from oct 9th 1941 to oct 9th 1941  
that I last saw her alive on oct 9th 1941  
and that death occurred on the date and hour stated above.Immediate cause of death Bronchopneumonia / infection Duration: 2 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Oliver F. Guffy (M. D. or other) moAddress Neuton mo Date signed oct 10th 1941

**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 Char W. Lyra

Licensed Embalmer No. 3109

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

2B  
21-41  
29288

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35006

Registration District No. 328

Primary Registration District No. 3017

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Trenton

(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Willa L McAttee

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 S

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 8  
(Month) (Day) (Year)

8. AGE: Years 2 Months - Days -  
(If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Broncho Pneumonia  
Infection

Due to \_\_\_\_\_

Due to Followed acute Coryza

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

107

Duration 2 days

Duration 2 days

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 Oliver F. Duff \_\_\_\_\_ (M.D. or other) \_\_\_\_\_

Address Trenton, Mo. \_\_\_\_\_

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

SUPPLEMENTARY

102 (1941)

