3. No. 2
4-41
-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10086

FILED APR 24 1942

Registration District No. ____ Primary Registration District No. 4021 5038 Registrar's No. ____

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

1. PLACE OF DEATH:

(a) County: Barry
(b) City or town: Cassville, Rural (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: ---
In this community: About Thirty Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Barry
(c) City or town: Cassville, Rural (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: Mattie Kirkland

3. (b) If veteran, name war: ---

3. (c) Social Security No.: ---

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: ---

6. (c) Age of husband or wife if alive: ___ years

7. Birth date of deceased: May (Month) 26 (Day) 1867 (Year)

8. AGE: Years 74 Months 8 Days 5 If less than one day ___ hr. ___ min.

9. Birthplace: --- (City, town, or county) Kansas (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: ---

FATHER
12. Name: John Betts
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary White
15. Birthplace: Ohio (City, town, or county) (State or foreign country)

16. (a) Informant: Jim Ford
(b) Address: Cassville, Missouri R.2

17. (a) removal (Burial, cremation, or removal) (b) Date thereof: Feb 4th 42 (Month) (Day) (Year)
(c) Place: burial or cremation: Paola, Kansas

18. (a) Signature of funeral director: Horine & Culver
(b) Address: Cassville, Missouri

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1 year 1942 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from 10:00 a.m. Feb. 1, 1942, to Feb. 1, 1942 that I last saw her alive on Feb. 1, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocarditis	10 hours
Due to: Massive coronary Thrombosis	10 hours
Due to: 94a	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

James L. Jackson M.D.
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: James L. Jackson M.D. ~~or other~~
Address: Cassville, Mo. Date signed: 2-3-43

1077 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 442-585
Date Filed APR 23 1942

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 E. Gordon Bennett

Licensed Embalmer No. 4213

P. O. Address Cassville Miss.

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

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

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10086

Registration District No. 29 Primary Registration District No. 5038 Registrar's No.

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural
(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 years, months or days)

In this community

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 Mattie Kirkland

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased May 26 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Mar. 6, 1942 (Date received local registrar) (b) Grace Willis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. Day year 1942 hour minute M.

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

Immediate cause of death	Duration
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY