

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 7 1943

Registration District No. 178

Primary Registration District No. 5947

Registrar's No.

1. PLACE OF DEATH:

(a) County: Shelby

(b) City or town: St James Rural
(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 years, months or days)

In this community: _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Shelby

(c) City or town: St James Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Henry Mathena

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex: Male 5. Color or Race: White

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

6. (b) Name of husband or wife: Mary A Mathena 6. (c) Age of husband or wife if alive: 37 years

7. Birth date of deceased: 6-8-1862
(Month) (Day) (Year)

8. AGE: Years: 80 Months: 9 Days: 27 If less than one day: _____ hr. _____ min.

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

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER { 12. Name: Phillip Mathena

13. Birthplace: Don't know 9
(City, town, or county) (State or foreign country)

14. Maiden name: " " 11 " 9

15. Birthplace: " " 11 " 9
(City, town, or county) (State or foreign country)

16. (a) Informant: Mary A Mathena

(b) Address: St James Mo

17. (a) Rural (b) Date thereof: 5-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Masonic Cem

18. (a) Signature of funeral director: J W K... ..

(b) Address: St James Mo

19. (a) 4-9-1943 (b) Chancellor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5
year 1943 hour 4:00 minute 0 M.

21. I hereby certify that I attended the deceased from out
_____ 1943 to 4 5 1943
that I last saw hm alive on 4 4 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Hep liver

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: C N Aubright (M. D. or other) _____
Address: St James Mo Date signed: 4-6-43

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

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 W. L. Licklider

Licensed Embalmer No. 1970

P. O. Address St James 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-104
Registrar's No. _____

Registration District No. 276

Primary Registration District No. 5-947

1. PLACE OF DEATH: Phelps Rural
(a) County _____
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Phelps
(c) City or town 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 Jenny Malenia
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
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 80 Months 9 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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 _____ Day _____
year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her 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: 1316
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 Dr. Fulbright (M. D. or other) _____
Address Adgomo Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-15104