

25574

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 1943

Registration District No. 236

Primary Registration District No. 5819

Registrar's No. 22

1. PLACE OF DEATH:

(a) County MORGAN

(b) City or town RURAL OSAGE

(c) Name of hospital or institution: 1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community 10 YRS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MORGAN

(c) City or town "RURAL" OSAGE
(If outside city or town limits, write "RURAL")

(d) Street No. 8 MILES SOUTH OF VERSAILLES
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME ARMAN A. MATTHEWS.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 15TH year 1943 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from about Oct 1, 1941 to July 15, 1943 that I last saw him alive on July 14, 1943 and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED.

6. (b) Name of husband or wife IOAB. HAWK. 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased JAN. 4, 1873
(Month) (Day) (Year)

Immediate cause of death coronary thrombosis Duration 1 Hr

8. AGE: Years Months Days If less than one day

70 7 11 hr. min.

Due to Hypertension & arterial sclerosis

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

Due to _____

10. Usual occupation DRUGGIST + GROCERY

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business DRUGS + GROCERY

Major findings: Of operations g & a

12. Name _____

Of autopsy _____

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

14. Maiden name _____

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

16. (a) Informant Mrs. A. A. Matthews.

(b) Address Versailles, Missouri

17. (a) BURIAL (b) Date thereof 7/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VERSAILLES, GEMTY

18. (a) Signature of funeral director H. F. T. Tull

(b) Address Versailles Mo

19. (a) 7-19-1943 (b) Ray Berkestrasser
(Date received local registrar) (Registrar's signature)

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 75

23. Signature A. J. Swan (M. D. _____)
Address Versailles Mo Date signed 7-19-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1027

RECEIVED
District Health Officer No. 7,
District File Number 7-43-775
Date Filed 8-6-43

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 A. F. Thruell

Licensed Embalmer No. 1596

P. O. Address Beaumont, La.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 20 1943
State File No. _____

Registration District No. 236

Primary Registration District No. 5819

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Rush Springs, Imp
(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

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Arman A. Matthews

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: Jan 4 (Month) (Day) (Year)

8. AGE: Years 20 Months 7 Days _____ (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (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) 8-12-1943 (Date received local registrar) (b) Roy Berkstesser (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 day _____ 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) _____

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)

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

S-25574