

FILED AUG 26 1943

State File No. _____

Registration District No. 139

Primary Registration District No. 4225

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Oregon
(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 31 years (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt

(c) City or town Oregon
(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 FRANK EVERETT MATTHEWS

3. (b) If veteran, name war No.

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1943 hour 10 minute 00 P.M.

21. I hereby certify that I attended the deceased from Frank, 1938, to July 19, 1943
that I last saw him alive on July 18, 1943
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married Divorced
Widowed

6. (b) Name of husband or wife Mary Welch

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

7. Birth date of deceased Jan. 5 1859
(Month) (Day) (Year)

Immediate cause of death: Coronary thrombosis
of the circumflex artery

Duration 3 yrs

8. AGE: Years 84 Months 6 Days 14
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

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

10. Usual occupation Undertaker & Furniture Dealer

Other conditions Coronary thrombosis
(Include pregnancy within 3 months of death)

PHYSICIAN H. B. P.

MOTHER FATHER

11. Industry or business _____

12. Name Noah Matthews

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

14. Maiden name Amanda Dwigley

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

16. (a) Informant Mrs Garfield Mathews

(b) Address 500 Progress Ave Norfolk Neb

17. (a) Renormal (Burial, cremation, or removal)

(b) Date thereof 7 22 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Schuyler Neb

18. (a) Signature of funeral director James H Pettigall

(b) Address Oregon

19. (a) _____ (Date received local registrar)

(b) _____ (Registrar's signature)

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? runway
(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 E F Kury (M. D. or other)

Address _____ Date signed _____

11850

AUG 19 1943

5-25072

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..... *James H. Pettigah*

Licensed Embalmer No. *31925*

P. O. Address..... *Oregon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.
Registrar's No. _____

Registration District No. 139

Primary Registration District No. 4225

1. PLACE OF DEATH:
(a) County Halt
(b) City or town Oregon
(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 31 yr. (years, months or days)

3. (a) PRINT FULL NAME Frank E. 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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 5 1885
(Month) (Day) (Year)
8. AGE: Years 84 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation Mathews

11. Industry or business _____
12. Name Frank Matthews
13. Birthplace unk.
(City, town, or county) (State or foreign country)
14. Maiden name Armande J. McKay
15. Birthplace unk.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Garfield Mathews
(b) Address 500 Oregon Ave, Norfolk - Neb.

17. (a) Removal (b) Date thereof 7-22/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Schuyler, Neb.

18. (a) Signature of funeral director Gamble H. Pittman
(b) Address Oregon - Mo.

19. (a) 7-27-43 (b) Pauline Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Halt
(c) City or town Oregon
(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 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver 2 yr. Duration _____

Due to _____
Due to _____
Other conditions Cerebral Hemorrhage
(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

MOTHER, FATHER

TEMPORARY

S= 25072