

35190

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 57Registration District No. 206Primary Registration District No. 3042

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Fredericktown
 (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 1
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Bert Joseph Matthews

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Annie Matthews 6. (c) Age of husband or wife if alive 59 years7. Birth date of deceased February 14th, 1887
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
56 8 10 _____ hr. _____ min.9. Birthplace Fredericktown Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Brick Mason

11. Industry or business _____

12. Name James Matthews13. Birthplace St. Genevieve Missouri
(City, town, or county) (State or foreign country)14. Maiden name Mary Jane Merrill15. Birthplace Ironton Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Annie Matthews(b) Address Fredericktown, Mo.17. (a) Burial (b) Date thereof 10-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Fredericktown, Mo.18. (a) Signature of funeral director Stanley A. Ripon(b) Address Fredericktown, Mo.19. (c) Oct. 28 1943 (b) S. C. S. Cavalito
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
 (c) City or town Fredericktown
 (If outside city or town limits, write "RURAL")
 (d) Street No. 719 West Main
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24th.
year 1943 hour 6:40 minute P. M.21. I hereby certify that I attended the deceased from Oct. 24 1943 to _____ 19____;
that I last saw him alive on Oct. 24 1943;
and that death occurred on the date and hour stated above.Immediate cause of death Angina Pectoris

Due to _____

Due to _____

Other conditions ✓
(Include pregnancy within 3 months of death)Major findings: ✓

Of operations _____

Of autopsy ✓

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 023. Signature S. C. S. Cavalito (M. D. or other) _____
Address Fredericktown Mo Date signed 10/28/43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

12. Name James Matthews13. Birthplace St. Genevieve Missouri
(City, town, or county) (State or foreign country)14. Maiden name Mary Jane Merrill15. Birthplace Ironton Missouri
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(Date received local registrar) (Registrar's Signature)

Duration

Five minutes

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4
District File Number 1143-289
Date Filed 11-8-43

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 Stanley H. Dixon
Licensed Embalmer No. 4193
P. O. Address Fredericktown, 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.