

FILED MAY 25 1944/9

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3926 Wyoming
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 yrs.
years, months or days

3. (a) PRINT FULL NAME Walter T. Matson

3. (b) If veteran, name was None 3. (c) Social Security No. None

4. Sex Male 5. Color or Race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elda June Matson 6. (c) Age of husband or wife if alive 60 yrs years
7. Birth date of deceased August 26, 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 05 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Harrison Co., Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Lawyer

11. Industry or business Self

MOTHER FATHER { 12. Name John Matson
13. Birthplace Harrison Co., Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Phoebe Marton
15. Birthplace Harrison Co., Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elda June Matson

(b) Address 3926 Wyoming

17. (a) Burial (b) Date thereof 5/18/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Walter T. Matson While at work? _____ (Specify type of place)

(b) Address 1901 Olathe Blvd. K. C. Mo. (c) Means of injury _____

19. (a) 5-16-44 (b) W. E. Brown (Registrar's Signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 3926 Wyoming (If rural, give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15th
year 1944 hour 9:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 14th 1944, to May 15th 1944
that I last saw him alive on May 15th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 day
Due to Arterio Sclerosis 5 yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
830

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?

23. Signature W. W. Slaughter (M. D. or other)
Address 4220 Bell St Date signed May 15-44

Dr. Slaughter
4320 Bell

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. M. S. N...

Licensed Embalmer No.....

3991

P. O. Address.....

309 E. 67th St.

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.