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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21904

Registration District No. 172

Primary Registration District No. 5641

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Palmyra
(b) City or town Higginsville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Doves Turp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Amanda Matthews

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Norman Matthews 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Oct 19 1881
(Month) (Day) (Year)

8. AGE: Years 56 Months 7 Days 22 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Norman Memershausen

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

14. Maiden name Amalia Grahmeyer

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

16. (a) Informant Norman Matthews

(b) Address Higginsville, Mo

17. (a) Burial (b) Date thereof 6-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director E. M. Memershausen

(b) Address Higginsville, Mo

19. (a) 6-13-1944 (b) Dr. W. A. Braeklin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Palmyra
(c) City or town Higginsville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Doves Turp 54
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1944 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from May 19, 1942
to June 8, 1944
that I last saw her alive on June 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 2 yrs.

Due to _____

Due to _____

Other conditions 93d
(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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature E. M. Memershausen (M. D. _____)
Address Higginsville, Missouri Date signed 6-13-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

400

1189

JUN 27 1949

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 Roy F. Wiegman

Licensed Embalmer No. 2883

P. O. Address Higginsville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 1110

Registration District No. 22

Primary Registration District No. 5641

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Hughesville rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hosp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution entire life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Amanda Mattheus

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

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

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

7. Birth date of deceased Dec 19
(Month) (Day) (Year)

8. AGE: Years 56 Months 17 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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)

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 June Day 19 Year 1946 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

SUPPLEMENTARY

MOTHER FATHER

21904