

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days
(Specify whether
In this community 27 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clark
(c) City or town Arkadelphia
(If outside city or town limits, write "RURAL")
(d) Street No. 1122 Fifth Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

3. (a) PRINT FULL NAME LEO W MATTOX

3. (b) If veteran, name war World War II 3. (c) Social Security No. 443-10-4082

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Thelma W Mattox 6. (c) Age of husband or wife if alive 44 NK years
7. Birth date of deceased January 26 1917
(Month) (Day) (Year)

8. AGE: Years 27 Months 8 Days 0 If less than one day hr. -- min.

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

10. Usual occupation Cashier & Bookkeeper
11. Industry or business Retail & Wholesale Grocery Co

MOTHER FATHER { 12. Name Robie L Mattox
13. Birthplace Temple Texas
(City, town, or county) (State or foreign country)
14. Maiden name Bernice King
15. Birthplace Poteau Oklahoma
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Bernice Mattox
(b) Address 716 N. Kickapoo Shawnee Okla
17. (a) Removal (b) Date thereof 28 Sept 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Shawnee, Oklahoma

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 9-28-44 (b) Dr W.S. Landry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1944 hour 12 minute 18 P. M.

21. I hereby certify that I attended the deceased from 31 August
19 44 to 26 September 19 44
that I last saw him alive on 26 September 19 44
and that death occurred on the date and hour stated above.
Immediate cause of death Toxemia, severe

Due to 3rd degree burns, thighs and legs, bilateral
Due to Accident incurred while he was demonstrating flame thrower

Other conditions ---
(Include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy Enlarged liver

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 8 August 1944
(c) Where did injury occur? Camp Phillips, Kansas
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Government reservation
While at work? Yes (Specify type of place) (e) Means of injury By flame thrower
23. Signature Delius Newman (M. D. of other) Mary Mc
Address 6 Kelly Center Springfield Mo Date signed Sept 26

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

A report submitted to the Bureau of the Census.

DEC 20 1947

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 *H. L. McCann*

Licensed Embalmer No. *2727*

P. O. Address *458 E Walnut*

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.

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