

FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12703

Registration District No. 10

Primary Registration District No. 5037

Registrar's No. 36

1. PLACE OF DEATH

(a) County Andrew
(b) City or town Rural - Salt River
(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
In this community 20 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME ROSA 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 George H. Matthews
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased Oct. 27 - 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 13
If less than one day hr. min.

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

10. Usual occupation HWY

11. Industry or business

MOTHER FATHER

12. Name J. A. Harris
13. Birthplace Va.
(City, town, or county) (State or foreign country)
14. Maiden name Raura Rock
15. Birthplace Howard Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Eva Malloy
(b) Address Cleburn Mo

17. (a) Burial (b) Date thereof Mar. 12 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cem.

18. (a) Signature of funeral director Barnes & Brothers
(b) Address Sturgeon, Mo.

19. (a) 3/12/45 (b) Margaret H. Machu
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Rural (Miss)
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 10 year 1945 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from Mar 9
1945 to Mar 10 1945
that I last saw him alive on Mar 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Central Haemorrhage

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 R. A. Woods (M. D. or other)
Address Clark St - 7245 Date signed 3/12/45

1074

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

4
0
0

RECEIVED

District Health Officer No. 10

District File Number 4-45-567

Date Filed APR 13 1945

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 E Boothe*.....

Licensed Embalmer No. 4087

P. O. Address *Sturgeon, 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.