S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24860

FILED AUG 10 1945

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 93

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 hrs. 35 min. (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94

(c) City or town Bismarck 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME THOMAS EDWARD (TOM) MATKIN

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

4. Sex Male 0 5. Color or race W. 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased October (Month) 26 (Day) 1901 (Year)

8. AGE: Years 43 Months 8 Days 22 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business .....

FATHER
12. Name Jess Matkin
13. Birthplace ..... (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Mary Coin
15. Birthplace ..... (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (Month) (Day) (Year)
(c) Place: burial or cremation I.O.O.F. Cem. Bismarck, Mo.

18. (a) Signature of funeral director Alvin Hood
(b) Address Flat River, Mo.

19. (a) 7/20/45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

1397

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18, year 1945 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 17, 1945, 19..., to July 18, 1945, 19...; that I last saw him alive on July 18, 1945, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to Hypertensive Cardiac vascular disease

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy No autopsy.

Duration

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? ..... (Specify type of place)

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

23. Signature [illegible] (M. D. or other) Md.

Address State Hosp. No. 4 Date signed 7-18-45

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 4
District File Number 845-952
Date Filed 8-9-45

OCT 8 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 Calvin von Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, 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.