S. No. 2
DM—5-43
v. 5-17-39
D I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37237

State File No. 37237

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 932

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: 419 S. Grant Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: Springfield
(If outside city or town limits, write "RURAL")
(d) Street No.: 419 S. Grant
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Emery Clyde Matthews
3. (b) If veteran, name war: M, UNK.
3. (c) Social Security No.: UNK.
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mrs. Margaret J. Matthews
6. (c) Age of husband or wife if alive: UNK. years
7. Birth date of deceased: February (Month) 15, (Day) 1878 (Year)

8. AGE: Years 67 Months 8 Days 27 If less than one day hr. min.

9. Birthplace: Galloway, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Unknown
11. Industry or business: Unknown
MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) UNK. (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) UNK. (State or foreign country)
16. (a) Informant: Mrs. Margaret J. Matthews
(b) Address: 419 S. Grant Ave., Spfd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/15/1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazelwood Cemetery
18. (a) Signature of funeral director: Alma Lohmeyer Funeral Home
(b) Address: Springfield, Missouri
19. (a) 11-14-45 (Date received local registrar) (b) E. W. Hanley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12, year 1945 hour 6: minute 30 P.M.
21. I hereby certify that I attended the deceased from Oct 1 1945 to Nov 12 1945 that I last saw him alive on Nov 12 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Angina Pectoris — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations:
Of autopsy: None

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: W. A. Webb (M. D. or other)
Address: Springfield Mo. Date signed 11/13/45

98 (Licensed Embalmer's Statement on Reverse Side)

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 C. A. Rauf

Licensed Embalmer No. 3644

P. O. Address Springfield Ind

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.