

1-5-42  
5-17-39  
X32873

**FILED APR 2 1946**

Registration District No. **305**

Primary Registration District No. **6047**

Registrar's No.

1. PLACE OF DEATH:

(a) County **St. Charles**  
(b) City or town **Wentzville Rural**  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 years**  
In this community **2 years**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** County **St. Charles**  
(c) City or town **Wentzville Rural**  
(d) Street No. **9**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME **Maymie May Mathews**

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

4. Sex **Female** 5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Charles Mathews**  
6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **May 8 1890**  
(Month) (Day) (Year)

8. AGE: Years **55** Months **9** Days **13**  
If less than one day hr. min.

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

10. Usual occupation **House duties**

11. Industry or business

12. Name **Wrs Luckett**

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

14. Maiden name **Ordie McLean**

15. Birthplace **Forestill West Virginia**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles Mathews**

(b) Address **Wentzville**

17. (a) **Burial** (b) Date interred **Feb 24 46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forestill Mo**

18. (a) Signature of funeral director **E. B. Kenna**

(b) Address **Wentzville Mo**

19. (a) **Feb 29 1946** (b) **Mrs Jess Lewis**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **21**  
year **1946** hour **11** minute **9** M.  
21. I hereby certify that I attended the deceased from **1944**  
19 to **Present** 1946

that I last saw him alive on **Feb 21 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart Disease**  
**arteriosclerosis**

Due to **arteriosclerosis**

Due to **Kidney trouble**  
**right**

Other conditions **right**  
(Include prominently within 3 months of death)

Major findings:  
Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Of autopsy **no**

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 **E. B. Kenna** (M. D. or other) **M.D.**  
Address **Wentzville Mo** Date signed **2-26-46**

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

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

MOTHER FATHER

**RECEIVED**  
District Health Officer No. 9,  
District File Number.....  
Date Filed 4-1-46

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**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 RE Pluman

Licensed Embalmer No. 2711

P. O. Address Wentzville, 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.**

Registration District No. 305

Primary Registration District No. 6047

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

9441

**1. PLACE OF DEATH:** St Charles  
 (a) County \_\_\_\_\_  
 (b) City or town \_\_\_\_\_  
 (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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 years, months or days)

**3. (a) PRINT FULL NAME** Mayme M. Mathew  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
 7. Birth date of deceased May 8 (Month) (Day) (Year)

8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 { 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 \_\_\_\_\_ (Month) (Day) (Year)  
 (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 Feb year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to Acute Myocardial Infarction  
following a 2 day illness  
 Due to Coronary artery disease  
characterized by atheromatous plaques  
 Other conditions Cholesterol deposits  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy no 130

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

10529