

FILED MAR 20 1946

Registration District No. **347**

Primary Registration District No. **4508**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Stone**
 (b) City or town **Galena mo**
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____ (Specify whether)
 In this community **4.5 yrs** years, months or days

3. (a) PRINT FULL NAME

Thomas David Mathes

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

4. Sex **m** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **widowed**

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

7. Birth date of deceased **Jan 10 1865** (Month) (Day) (Year)

8. AGE: Years **81** Months **1** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Tracer man**

11. Industry or business **mail carrier**

12. Name **David Mathes**

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

14. Maiden name **Sarah Prichard**

15. Birthplace **mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Andrew Walters**

(b) Address **Galena mo**

17. (a) **Burial** (b) Date thereof **March 10 46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Galena Cemetery**

18. (a) Signature of funeral director **Eriett J. Cheatham**

(b) Address **Galena mo**

19. (a) **March 9 46** (b) **Lena Murray** (Date received local registrar) (Registrar's signature)

(c) **Dip.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stone 104**
 (c) City or town **Galena** (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 **March** day **7th** year **1946** hour **12 noon** minute _____

21. I hereby certify that I attended the deceased from **at Death** **1946** to **1946** that I last saw **live** on **March 7th** and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure** Duration **1 day**

Due to _____

Due to _____

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

Major findings: Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED** 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) Means of injury **car**

23. Signature **Eriett J. Cheatham** (M-D or other) **Coroner** Address **Galena mo.** Date signed **3-8-46**

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 *Everett J. Cheatham*

Licensed Embalmer No. *3870*

P. O. Address *Halena, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 347

Primary Registration District No. 4508

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Salena
(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.....
years, months or days)

3. (a) PRINT FULL NAME

Thomas O. Mather

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: Years 81 Months Days If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (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 April Day 7
Year 1946 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 severe pain

Due to Gas Duration.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... 200

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury.....
23. Signature Earl J. Cheatham (M. D. or other) Coroner
Address..... Date signed.....

SUPPLEMENTARY

11946