

**FILED** APR 24 1946

Registration District No. 12.8

Primary Registration District No. 2000

Registrar's No. 307

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:  
2517 East Avenue  
(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 William L. Mathews

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

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased: Sept. (Month) 17 (Day) 1859 (Year)

8. AGE: Years 86 Months 6 Days 19 If less than one day hr. min.

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

10. Usual occupation Miller

11. Industry or business

12. Name John Matthews

13. Birthplace UNK. (City, town, or county) unknown (State or foreign country)

14. Maiden name Elizabeth Montgomery

15. Birthplace UNK. (City, town, or county) unknown (State or foreign country)

16. (a) Informant Frank H. Matthews

(b) Address 2517 E. Ave. Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-46 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. Klingner & Co.

(b) Address Springfield, Mo.

19. (a) 4-8-46 (Date received local registrar) (b) S. W. E. Rauscher (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2517 E. Ave. 6  
(If rural, give location) 0  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1946 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Mar. 1 - 1946 to Apr. 6, 1946 that I last saw him live on Apr. 5 - 1946 and that death occurred on the date and hour stated above.

Immediate cause of death acute subarachnoid hemorrhage Duration unk.

Due to hypertension

Other conditions Degenerative Cardiovascular disease (Include pregnancy within months of death)

Major findings: arteriosclerosis PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 1200 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 \_\_\_\_\_ (Specify means of injury) \_\_\_\_\_

23. Signature Robert K. Kraft (M. D. or other) MD.  
Address 450 E. 1st St. Date signed 4-6-46

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

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 *Max Rhodes*  
Licensed Embalmer No. *4071*  
P. O. Address *Springfield*

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.

X