

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

16445

State File No. ....

FILED MAY 27 1948  
Registration District No. 135

Primary Registration District No. 5496

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Warren  
(b) City or town Rural Mount Top  
(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. 67 years (Specify whether years, months or days)  
In this community 67 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Warren  
(c) City or town Engleville  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country .....

3. (a) PRINT FULL NAME Nellie Maude Mathes

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Keppu Mathes Dec. 6. (c) Age of husband or wife if alive 7 years  
7. Birth date of deceased Nov 7 1975  
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 25 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business .....

MOTHER FATHER  
12. Name Edward Alston  
13. Birthplace Hamilton Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Almira Choate  
15. Birthplace Ambuland Co Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Asa Comer  
(b) Address Ridgway Mo

17. (a) Burial (b) Date thereof Jan 4 1986  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hobbs Chapel Church

18. (a) Signature of funeral director Joe E Wheeler  
(b) Address Lebanon Mo

19. (a) 1-4-46 (b) Lekita New  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2  
year 1946 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from Nov. 11-28, 1945, to 11-28, 1945.  
that I last saw her alive on 11-28, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes & complications of gangrene on left foot

Due to .....

Due to .....

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

Major findings: Of operations (a)  
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? .....

(Specify type of place) While at work? (e) Means of injury 2

23. Signature Bessie Wood D.O.  
Address Bethany, Mo Date signed 1/7/46

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.....

*Joe E. Wheeler*

Licensed Embalmer No. *3512*

P. O. Address... *Bethany 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.**