

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 372 Primary Registration District No. 4543 State File No. 32524 Registrar's No. 19

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Re Seymour
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Seymour
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 9 months _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Rose Angelia Matney
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex f / 5. Color or race w
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Ernest Matney
13. Birthplace Webster County MO
(City, town, or county) (State or foreign country)
14. Maiden name Florence Coville
15. Birthplace Manchester Conn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Florence Coville
(b) Address Seymour MO
17. (a) Burial 9/11/46 (b) Date thereof Aug 12 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ston Cemetery

18. (a) Signature of funeral director Kelly, Ferrell Bagna
(b) Address Seymour MO
19. (a) Sept 14 (b) Hilbert Jones
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Webster
(c) City or town Seymour R2
(If outside city or town limits, write "RURAL")
(d) Street No. Seymour R2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION:
20. DATE OF DEATH: Month Aug day 11
year 1946 hour 6 minute 4:30 PM
21. I hereby certify that I attended the deceased from Aug - 10
_____ 1946, to Aug _____ 1946;
that I last saw her alive on Aug 9 11 _____ 1946
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY ATRESIA Duration 1 day
Due to TRAUMA

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
157M

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 A. J. R. Hill (M. D. or other) No
Address Seymour MO Date signed 8-2-46

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

RECEIVED.

District Health Officer No. 6,

District File Number 946-976

Date Filed SEP 15 1946

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.....

Licensed Embalmer No.....

P. O. Address.....

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.