

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

FILED MAY 29 1947

Registration District No. 171

Primary Registration District No. 4267

Registrar's No. 2

1. PLACE OF DEATH  
 (a) County Lafayette  
 (b) City or town Odessa  
 (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 Life (Specify whether  
 In this community Life years, months or days)

3. (a) PRINT FULL NAME Comilla H. Mathews  
 3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

4. Sex Fe / 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife John Mathews 6. (c) Age of husband or wife if alive 70 years  
 7. Birth date of deceased March 15 1885  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 11 23 hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name William Tinner  
 13. Birthplace Kansas (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Bollinger  
 15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant John Mathews

(b) Address Odessa, Mo.

17. (a) Burial (b) Date thereof Mar. 10, 1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Odessa, Mo.

18. (a) Signature of funeral director Husman-Sparks, Odessa Mo.

(b) Address Odessa Mo.

19. (a) April 26 '47 Letta Drummond (Date received local registrar) (Registrar's signature) LSR

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Lafayette 54  
 (c) City or town Odessa (If outside city or town limits, write "RURAL") 4  
 (d) Street No. .... (If rural, give location) 0  
 (e) Citizen of foreign country? No (Yes or No) 0  
 If yes, name country .....

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March day 8  
 year 1947 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 20, 1945  
 19... to Mar 9 19...  
 that I last saw him alive on Mar 8 19...  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration

Due to hypertension & cardio-vascular disease

Due to long years duration

Other conditions (Include pregnancy within 3 months of death) 938

Major findings: Of operations

Of autopsy see certificate 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 0

23. Signature MR Martin MD (M. D. or other) 0

Address Odessa Mo Date signed 3/17/47

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 5-22-47

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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 George T. Heisman

Licensed Embalmer No. 2541

P. O. Address Odessa, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Jung Lafayette*

*Jung Lafayette*  
2

Registration District No. *171*

Primary Registration District No. *4267*

Registrar's No. *2*

1. PLACE OF DEATH:

(a) County *Lafayette*  
(b) City or town *Adessa*  
(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 *Camilla H. Mathew*

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 *M*

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

7. Birth date of deceased *March 15* (Month) (Day) (Year)

8. AGE: Years *61* Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

9. Birthplace *Mo. C* (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

*April 26 1947* (Date received local registrar) *Latta* (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 \_\_\_\_\_ year *1947* month \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

Of autopsy \_\_\_\_\_ 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 \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAY NOT PERMANENT RECORD

SUPPLEMENTARY

17964