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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 3 1947
 Registration District No. 574

Primary Registration District No. 6273

Registrar's No. 67

1. PLACE OF DEATH:
 (a) County Worth
 (b) City or town Rural-Fletchall Township
 (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 2 months
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Worth
 (c) City or town Rural
 (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 _____

3. (a) PRINT FULL NAME Oscar Mathis
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex male 5. Color or white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased December 25, 1879
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 14
 year 1947 hour 9 minute 40 P. M.
 21. I hereby certify that I attended the deceased from 1 Oct
1947 to Oct 14 1947
 that I last saw him alive on 13 Oct 1947
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
67 9 19 hr. _____ min.

Immediate cause of death:
Decinomia by wood Colon tumor
 Duration _____

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

Due to _____
 Due to _____

10. Usual occupation _____
 11. Industry or business farming
 12. Name William Mathis
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary (unknown)
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Decinomia by wood Colon tumor
 Major findings: vacuolar disease
 Of operations _____
 Of autopsy H&E
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant William Roach
 (b) Address Grant City, Mo.
 17. (a) burial (b) Date thereof 10-16-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Allendale Cemetery
 18. (a) Signature of funeral director Arch C. Dwyer
 (b) Address Grant City, Mo
 19. (a) 10-24-47 (b) Leta E. Dawson
 (Date received local registrar) (Registrar's signature)

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)
 23. Signature Frank B. Mathis (M. D. or other)
 Address Grant City Mo Date signed 10/14/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

13
 0
 0

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Arch C. Duffee*

Licensed Embalmer No. *3252*

P. O. Address *Hunt City, 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.