

S. No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 17 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12757
Registrar's No. 1546

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. (Specify whether
In this community 40 yrs
years, months or days)

3. (a) PRINT FULL NAME John B. Mattox
3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mary Katherine Mattox 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 5 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 00 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Car & Furniture Dealer

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Kathryn Dailey
(b) Address 7510 Washington

17. (a) Burial (b) Date thereof 4-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park K.C.

18. (a) Signature of funeral director Francis Wornall
(b) Address 7406 Wornall Rd

19. (a) 4-8-48 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 7510 Washington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
year 1948 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from
March 6 1948 to April 5 1948;
that I last saw him alive on April 5 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death
Terminal bronchopneumonia
Senile dementia

Due to _____

Due to _____

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

Major findings:
Of operations 107
Of autopsy None

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 fall

23. Signature Wm W. Hart (M. D. or other) Med. Dir. Gen'l Hosp.
Address _____ Date signed 4-6-48

Dr. Ridings

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 *Russell W. France*

Licensed Embalmer No. *4255*

P. O. Address *K. C. 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.