

FILED AUG 16 1948
Registration District No. **39**

Primary Registration District No. **4097**

Registrar's No. **143**

1. PLACE OF DEATH:
(a) County **Cass**
(b) City or town **Harrisonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **701 W. WALL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME **LEE MATTHEWS**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **12**
year **1948** hour **7:50** minute **A** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, Married, Divorced
6. (b) Name of husband or wife **Ollie Matthews**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Jan 1 1877**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 1 1948** to **Aug 12 1948** that I last saw him alive on **Aug 9 1948** and that death occurred on the date and hour stated above.

8. AGE: Years **71** Months **07** Days **11** If less than one day

Immediate cause of death **Basilar Paralysis**
Senile Degeneration

9. Birthplace **Columbus, Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Machinist - Retired**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: **g.v.**

MOTHER FATHER

11. Industry or business
12. Name **James Matthews**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Das Walgen Das**
15. Birthplace **Johnson Co. Mo.**
(City, town, or county) (State or foreign country)

Of operations
Of autopsy
PHYSICIAN
Underline the cause of which death should be charged statistically.

16. (a) Informant **Mrs. Ollie Matthews**
(b) Address **Harrisonville, Mo.**
17. (a) Burial, cremation, or removal **burial** (b) Date thereof **8-14-48**
(Month) (Day) (Year)
(c) Place: burial or cremation **Oakland Cemetery**
18. (a) Signature of funeral director **RUNNENBURGER'S**
(b) Address **HARRISONVILLE, MO.**
19. **Aug. 13, 1948** (Date received local registrar)
Laura J. Jones (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)
While at work (Specify type of place)
23. Signature **L. J. Jones** (M. D. or other)
Address **Harrisonville** Date signed **8-13-48**

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 _____

Ernest Ramminger

Licensed Embalmer No. 3368

P. O. Address Harrisonville

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.