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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31728

FILED OCT 1 1948

State File No. _____

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 99

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

1. PLACE OF DEATH: **Scott**

(a) County _____

(b) City or town **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Sikeston General Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days**
(Specify whether _____)

In this community **years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **New Madrid** ⁷²

(c) City or town **Morehouse** ³
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) ¹

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **William Hartzell Mathis**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Grace P.**

6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **Oct. 28 1878**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | 71 | 10 | 11 | hr. _____ min. |

9. Birthplace **Massica Co.** **Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation **Mill Worker**

11. Industry or business _____

MOTHER FATHER

12. Name **Wick**

13. Birthplace **Wick** ⁹
(City, town, or county) (State or foreign country)

14. Maiden name **Wick**

15. Birthplace **Ill** ⁹
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Grace P. Mathis**

(b) Address **Morehouse Mo.**

17. (a) **Burial** (b) Date thereof **9/11/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston Mo.**

18. (a) Signature of funeral director **WELSH FUNERAL HOME**

(b) Address **SIKESTON MISSOURI**

19. (a) **9-28-48** (b) **Mrs. G.P. Henry**
(Date received local registrar) (Registrar's signature) ^{2/2}

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9**
year **1948** hour **8** minute **15** P. M.

21. I hereby certify that I attended the deceased from **8-1**
19 **48** to **9-9** 19 **48**;
that I last saw him alive on **9-9** 19 **48**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations **4/6**

Of autopsy _____

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 **D**

23. Signature **Dr. J. J. Saxo M.D.** (M. D. or other) _____
Address **Morehouse Mo.** Date signed **9-17-48**

RECEIVED

District Health Office No. 2,

District File Number 948-1244

Date Filed 9-29-48

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.