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FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23113
State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 699

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If rural, give location) 514 West Walnut	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Henry	c. (Last) Matthews	4. DATE OF DEATH (Month) (Day) (Year) Aug. 6 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 6-23, 1877	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 1 Days 13	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Clinton, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John W. Matthews	13b. MOTHER'S MAIDEN NAME Mary Ellen Smith	14. NAME OF HUSBAND OR WIFE Deceased (Bessie Anna)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 491-05-0238	17. INFORMANT'S SIGNATURE OR NAME Clifford Matthews	ADDRESS 731 S. Grant.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4200
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7/17, 1949, to 8/6, 1949, that I last saw the deceased alive on 8/6, 1949, and that death occurred at 1 P.M., from the causes and on the date stated above.

23a. SIGNATURE Edward Marcus II M.D. (Degree or title)	23b. ADDRESS 623 Woodruff Bldg	23c. DATE SIGNED 8/8/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-8-1949	24c. NAME OF CEMETERY OR CREMATORY White Chapel Gardens	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
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DATE REC'D BY LOCAL REG. 8-8-49	REGISTRAR'S SIGNATURE W.E. Handley M.D.	FEDERAL DEPARTMENT OF HEALTH SIGNATURE W.L. Dunn	ADDRESS Springfield, Mo.
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(Licensed Embalmer's Statement of Reverse Side)

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

39
2
6

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *R. L. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield, 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.