

FILED AUG 3 1950

STANDARD CERTIFICATE OF DEATH

Dr. Kelly 23358  
State File No. 663

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 663

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Greene</b>	
b. CITY OR TOWN <b>Rural N. Campbell Twp.</b>		c. CITY OR TOWN <b>Springfield Rural N. Campbell Twp.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Evans Rest Home (Rt. 2)</b>		d. STREET ADDRESS (If rural, give location) <b>RFD # 2, Box 529R</b>	

3. NAME OF DECEASED (Type or Print) <b>William M. Matthews</b>			4. DATE OF DEATH <b>July 25, 1950</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Unknown</b>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>88</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Jeremiah Matthews</b>	13b. MOTHER'S MAIDEN NAME <b>Phoebe</b>	14. NAME OF HUSBAND OR WIFE <b>XX</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Evans Rest Home, Springfield, Missouri</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carbo Hemorrhage</b>		DUE TO (b) _____		331X
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-19, 1949**, to **7-25, 1950**, that I last saw the deceased alive on **7-24, 1950**, and that death occurred at **11:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W Kelly MD</b> (Degree or title)	23b. ADDRESS <b>Springfield MO</b>	23c. DATE SIGNED <b>7-26-50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial (1)</b>	24b. DATE <b>July 27, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>
DATE REC'D BY LOCAL REG. <b>7-28-50</b>	REGISTRAR'S SIGNATURE <b>W E Landley MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Lohmeyer, Springfield, Missouri</b>

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

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**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

*Walter E. Harvath*

Licensed Embalmer No.

*3808*

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.