

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. W. Johnson  
State File No. **24187**  
Registrar's No. **739**

FILED AUG 11 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>GREENE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dallas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. LENGTH OF STAY (In this place) <b>4 days</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>Rural Route 1</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>RILEY</b> c. (Last) <b>MATHEWS</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Aug. 4, 1952</b>	
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<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>Oct. 10, 1899</b>		<b>9. AGE</b> (In years last birthday) <b>52</b> Months <b>9</b> Days <b>25</b> Hours <b>1</b> Min.	
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Crown Farm</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
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<b>13a. FATHER'S NAME</b> <b>John B. Mathews</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Bell Vest</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Mrs. Edith Mathews</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs Edith Mathews</b>		<b>ADDRESS</b> <b>Buffalo, Mo.</b>	
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 wks</b>	
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Bronchopneumonia</b>							
		<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____							
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized atherosclerosis Chronic acute glomerulonephritis Hepatitis</b>									

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP)</b> <b>Buffalo</b> (COUNTY) <b>Greene</b> (STATE) <b>Mo.</b>	
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____			<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
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**22. I hereby certify that I attended the deceased from 8-1, 1952, to 8-4, 1952, that I last saw the deceased alive on 8-4, 1952, and that death occurred at 9:25 A.M., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <b>Harold B. Johnson, M.D.</b> (Degree or title)		<b>23b. ADDRESS</b> <b>Med Arts Bldg, Springfield, Mo.</b>		<b>23c. DATE SIGNED</b> <b>8-4-52</b>	
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>24b. DATE</b> <b>Aug 4, 1952</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>New Hope</b>		<b>24d. LOCATION</b> (City, town, or county) <b>Buffalo, Mo.</b> (State) <b>Mo.</b>	
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<b>DATE REC'D BY LOCAL REG.</b> <b>8-8-52</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Edith Williamson</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Louis</b>		<b>ADDRESS</b> <b>Buffalo, Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

AUG 14 1952

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 Morris B Jones

Licensed Embalmer No. 4323

P. O. Address Buffalo, 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.