

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5105

State File No. ....

FILED MAR 10 1953

REG. DIST. NO. 387

PRIMARY REG. DIST. NO. 4085

Registrar's No. 6

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

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hale, Mo.</u>	c. LENGTH OF STAY (in this place) <u>1 year</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hale, Mo.</u> <u>0170</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hale Mo. city</u>		d. STREET ADDRESS (If rural, give location) <u>city.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>ELLEN</u>	c. (Last) <u>MATTOX</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 6 1953</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 5-1869</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>	IF UNDER 1 HR. Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Shoals, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Jonathan Stiles</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Walker</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Mattox</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Lena Rearden</u>	ADDRESS <u>Carrollton, Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		
	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"/>
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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)	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 Feb 27, 1953, to March 6, 1953, that I last saw the deceased alive on March 6, 1953, and that death occurred at 7:55 P.M.; from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>D. Alvin A. Welsh # 20</u>	23b. ADDRESS <u>Hale, Mo</u>	23c. DATE SIGNED <u>3-7-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/8/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>	24d. LOCATION (City, town, or county) (State) <u>Boyard, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Mar. 7, 1953</u>	REGISTRAR'S SIGNATURE <u>Mrs Rex Henderson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. A. Dickerson</u>	ADDRESS <u>Boyard, Mo.</u>
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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 E. A. Dickerson.....

Licensed Embalmer No. 2534.....

P. O. Address Bogard, 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.