

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No.

11269

 BIRTH NO. FILED MAY 3 1954 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 423

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>	c. LENGTH OF STAY (In this place) <u>1 day</u>	c. CITY OR TOWN <u>Rural Wayne</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>Halls, Missouri</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JESS</u>	b. (Middle)	c. (Last) <u>MATTHEWS</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>18</u> (Year) <u>1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-26-1872</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Buchanan Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Matthews</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Hise</u>	14. NAME OF HUSBAND OR WIFE <u>Bertha Matthews (de)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Roy Whittington, Halls, Missouri</u>	ADDRESS <u>Halls, Missouri</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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastric Hemorrhage (etiology - unknown) (de)</u>		<u>unknown</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Severe Arteriosclerosis (Generalized)</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 <u>4500</u>	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) (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 July 11, 1953, to April 18, 1954, that I last saw the deceased alive on April 18, 1954, and that death occurred at 6:50 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Sharon E. Wagoner M.D.</u>	(Degree or title)	23b. ADDRESS <u>301 Illinois Ave.</u>	23c. DATE SIGNED <u>4-21-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-20-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Halls, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Apr. 26, 1954</u>	REGISTRAR'S SIGNATURE <u>Bertha M. Allison</u>	485- <u>0</u>	FUNERAL DIRECTOR'S SIGNATURE <u>John E. Clapp</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 39

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.