

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 20 1955

State File No. 29358

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4168 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <b>D DeKalb</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maysville</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maysville</b>	
c. LENGTH OF STAY (In this place) <b>8 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>0220</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Shaffer Rest Home</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Hannah</b>	b. (Middle) <b>Elizabeth</b>	c. (Last) <b>Mathews</b>	4. DATE OF DEATH (Month) <b>8-</b> (Day) <b>12-</b> (Year) <b>55</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-8-1876</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Mo,</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Calvin Moore</b>	13b. MOTHER'S MAIDEN NAME <b>Serona Thornton</b>	14. NAME OF HUSBAND OR WIFE <b>Gas Mathews</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Gas Mathews</b> ADDRESS <b>Fairport Mo</b>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		<b>1 week</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>arteriosclerosis</b>		<b>1946</b>
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 <b>331x</b>	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) (m.)	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 June, 1946 to 8/12, 1955, that I last saw the deceased alive on 8/11, 1955, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W.C. Harold Fowler M.D.</b>	23b. ADDRESS <b>Maysville Mo</b>	23c. DATE SIGNED <b>8/15/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-14-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fairport</b>	24d. LOCATION (City, town, or county) (State) <b>Fairport Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9-15-55</b>	REGISTRAR'S SIGNATURE <b>Roscoe Davidson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John Brown</b> ADDRESS <b>Maysville Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

29358

**STATEMENT BY LICENSED EMBALMER**

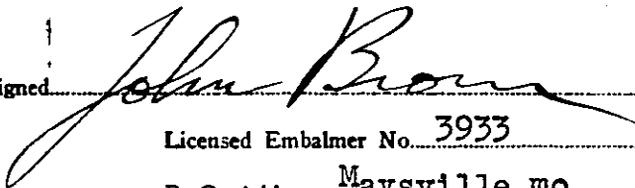
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed



Licensed Embalmer No. 3933

P. O. Address Maysville 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.