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FILED AUG. 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27593**

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **3041** Registrar's No. **163**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Callao	
c. LENGTH OF STAY (in this place) 5 weeks			
d. FULL NAME OF HOSPITAL OR INSTITUTION Samaritan hospital		d. STREET ADDRESS (If rural, give location) -----	

3. NAME OF DECEASED (Type or Print)	a. (First) Myrtle	b. (Middle) Jobson	c. (Last) Mathis	4. DATE OF DEATH (Month) (Day) (Year) July 17, 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 31, 1867	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 6 Days 16	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Macon, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Thomas Jobson	13b. MOTHER'S MAIDEN NAME Isabelle Frances Taylor Spencer B. Mathis	14. NAME OF HUSBAND OR WIFE Spencer B. Mathis
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----	17. INFORMANT'S SIGNATURE OR NAME Spencer B. Mathis, Callao, Mo.	ADDRESS -----
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio renal insufficiency		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) gastro intestinal hemorrhage 10 days		
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) (m.)	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 **June 16, 1956** to **July 17, 1956**, that I last saw the deceased alive on **July 17, 1956**, and that death occurred at **12:16 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Donald E. Eggleston MD	23b. ADDRESS Macon, Missouri	23c. DATE SIGNED July 24, 1956
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-19-1956	24c. NAME OF CEMETERY OR CREMATORY Columbia Cemetery	24d. LOCATION (City, town, or county) (State) Columbia, Mo.
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DATE REC'D BY LOCAL REG. 8/1/56	REGISTRAR'S SIGNATURE Ruth M. Neely	25. FUNERAL DIRECTOR'S SIGNATURE F. J. Billiland	ADDRESS New Columbia Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

MARK 2 2 1957

JUN 11 1957

Date Filed 8/14/50

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

A. J. Williams

Signed _____
Student Embalmer

Licensed Embalmer No. 4019

P. O. Address New Cambria Md

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.