

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021996
STATE FILE NUMBER

FILED JUN 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2810

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Nevada	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4208 Indiana		d. STREET ADDRESS (If outside give location) 108th 329 N. Cedar	
3. NAME OF DECEASED (Type or print) First FRANCES Middle ELIZABETH Last MATLOCK		4. DATE OF DEATH Month June Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81
11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Proctor		13b. MOTHER'S MAIDEN NAME Sarah Lee	14. NAME OF HUSBAND OR WIFE Robert W Matlock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs Margaret Dolan 4208 Indiana K C Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) myocardial infarct DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6:20
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from May 1952 , to present and last saw her alive on May 26, 1958 Death occurred at 2108 W. 10th St on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Roy F. Drake M.D.	
22b. ADDRESS 1032 Professional Building		22c. DATE SIGNED 6-3-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/3/58	
23c. NAME OF CEMETERY OR CREMATORY Oaks Hill		23d. LOCATION (City, town, or county) (State) Nevada Missouri	
24. FUNERAL DIRECTOR Shell Funeral Home Kansas City Mo		25. DATE RECD. BY LOCAL REG. 6-3-58	
26. REGISTRAR'S SIGNATURE Neve Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Roy F. Drake



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 *James B. Paul*

Licensed Embalmer No. *4854*

P. O. Address *D.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.