

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026356
STATE FILE NUMBER

FILED AUG 11 1958 Registration District No. 242 Primary Registration District No. 5830 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. In this situation: Residence before * a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Matthews</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Matthews</u> 6720
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>_____</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Bishop</u> Last <u>Rather</u>			4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1900</u>		9. AGE (In years last birthday) <u>57</u>
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>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Frammond, Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>J.W. Rather</u>		13b. MOTHER'S MAREN NAME <u>Corra Dennis</u>		14. NAME OF HUSBAND OR WIFE <u>_____</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Bertha Rather-Matthews, Mo</u> Address <u>_____</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>			<u>18 mo</u>
DUE TO (c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>_____</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>_____</u>	
21. I attended the deceased from <u>11/29/50</u> to <u>12/6/57</u> and last saw <u>her</u> alive on <u>12/6/57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>Wm. C. Cretchlow M.D.</u>		22b. ADDRESS <u>Sikeston, Mo</u>		22c. DATE SIGNED <u>July 21, 1958</u>	
--	--	-------------------------------------	--	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 22, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Matthews Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Matthews, Mo.</u>	
24. FUNERAL DIRECTOR <u>Albritton Funeral Home</u>			25. DATE RECD. BY LOCAL REG. <u>7-24-58</u>		26. REGISTRAR'S SIGNATURE <u>Kathryn L. M. Bain</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. All diseases in Part I must be causally related. All diseases in Part I must be causally related.

300
1-57
/

17
C

DATE RECEIVED JUL 29 1958
NEW MADRID CO. HEALTH CENTER
P. G. S.

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 *E. J. Smith*

Licensed Embalmer No. 3676

P. O. Address Oran, 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.