

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021971
STATE FILE NUMBER

FILED JUN 26 1959 Registration District No. 160 Primary Registration District No. 559 Registrar's No. 90

| | | | | | | | |
|--|-----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFF</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOACHIM TWP.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>DE SOTO</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEFF MEMORIAL Hosp</u> | | | Length of stay in lb <u>4 days</u> | 55 th STREET ADDRESS (If outside, give location) <u>Route #1</u> | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>MATHIS</u> Last <u>MATHIS</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1959</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB 2, 1888</u> | | 9. AGE (In years last birthday) <u>71</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE MANAGER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>KROGERS</u> | | 11. BIRTHPLACE (City and state or country) <u>POPLAR BLUFF, MO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>WILLIAM MATHIS</u> | | | 13b. MOTHER'S MAIDEN NAME <u>ELIZABETH WELCH</u> | | | 14. NAME OF HUSBAND OR WIFE <u>CORA MATHIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>497-09-0491</u> | | 17. INFORMANT Address <u>CORA MATHIS R1 De Soto, Mo</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>Chronic Nephritis</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 <u>10 yrs</u> <u>3</u> | |
| 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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u> | | | 20d. INJURY OCCURRED WHILE AT <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.) | | 20f. CITY, TOWN, OR LOCATION | | | COUNTY | | STATE |
| 21. I attended the deceased from Death occurred at <u>1245 1/2 W. 1949</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | to <u>6/16/59</u> and last saw her alive on <u>6/16/59</u> | | him <u> </u> | |
| 22a. SIGNATURE (Degree or title) <u>Chas E Faller M.D.</u> | | | | 22b. ADDRESS <u>De Soto Mo</u> | | 22c. DATE SIGNED <u>6/17/59</u> | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u> | 23b. DATE <u>JUNE 18, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u> | | 23d. LOCATION (City, town, or county) (State) <u>POPLAR BLUFF MO</u> | | | |
| 24. FUNERAL DIRECTOR <u>MAHN Funeral Home</u> | | | ADDRESS <u>De Soto, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-17-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Lucas G. Taylor</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

JUN 24 1955

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 *Gerald J. Maher*
Licensed Embalmer No. *4975*
P. O. Address *De Soto, 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.