

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 23 1959 38

59-038964

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 5122 Registrar's No. 561

ENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallsville</u> <small>Rocky Fork</small>		Length of stay in 1b <u>20 YRS.</u>	c. CITY OR TOWN <u>Hallsville</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>R. F. D. # 2</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. D. # 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rodney</u> Middle <u>I.</u> Last <u>Mathers</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</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>July 24-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>20</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>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Ainsworth, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Mathers</u>		13b. MOTHER'S MAIDEN NAME <u>Lillie Cates</u>		14. NAME OF HUSBAND OR WIFE <u>E. Alice Mathers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>E. Alice Mathers, Hallsville, Mo.</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
IMMEDIATE CAUSE (a) <u>hypostatic pneumonia</u>		
DUE TO (b) <u>encephalomalacia and multiple cerebral artery thromboses</u>		<u>years</u>
DUE TO (c) <u>cerebral arteriosclerosis</u>		<u>years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic heart disease &amp; cardiac decompensation</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

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.)	20f. CITY, TOWN, OR LOCATION <u>Centralla, Missouri</u>	STATE
21. I attended the deceased from <u>8/24/57</u> to <u>11/14/59</u> and last saw her alive on <u>11/14/59</u> Death occurred at <u>5:15 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Dr. J. Ward MD</u> (Degree or title)	22b. ADDRESS <u>Centralla, Missouri</u>	22c. DATE SIGNED <u>11-16-59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/17/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u>
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24. FUNERAL DIRECTOR <u>Paul J. Ballou, Centralla, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Nov. 17 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Paul S. Ballew

Licensed Embalmer No. 4206

P. O. Address Centralia, WA

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.